

Get Healthy Idaho: Measuring and Improving Population Health

Year 3 Update January 2018



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH



Acknowledgments

The Idaho Department of Health and Welfare, Division of Public Health would like to acknowledge the contributions of the following organizations to the *Get Healthy Idaho: Measuring and Improving Population Health* initiative and thank them for their continued support:

American Heart Association
Bingham Memorial Hospital
Blue Cross of Idaho
Boise State University – College of Health Sciences
Central District Health Department
Eastern Idaho Public Health
Idaho Academy of Family Physicians
Idaho Academy of Nutrition and Dietetics
Idaho Chapter – American Academy of Pediatrics
Idaho Department of Health and Welfare, Division of Behavioral Health
Idaho Department of Health and Welfare, Division of Medicaid
Idaho Department of Health and Welfare, Division of Public Health
Idaho Department of Health and Welfare, Division of Support Services
Idaho Department of Health and Welfare, Office of Healthcare Policy Initiatives
Idaho Foodbank
Idaho Healthcare Coalition
Idaho Health Professional Education Council and Family Medicine Residency of Idaho
Idaho Hospital Association
Idaho Oral Health Alliance
Idaho Primary Care Association
Idaho State University, Meridian
Jannus, Inc. – Formerly Mountain States Group
Medical Management, Inc.
Mercer, LLC
Panhandle Health District
Public Health – Idaho North Central District
Qualis Health
St. Alphonsus Health System
St. Luke's Health System
South Central Public Health District
Southeastern Idaho Public Health
Southwest District Health
Terry Reilly Health Services
United Way of Treasure Valley
University of Idaho

Table of Contents

Acknowledgments	1
Table of Contents	2
Message from the State Health Official	3
Introduction	5
Advancing Population Health	6
Statewide Healthcare Innovation Plan (SHIP)	8
Get Healthy Idaho - Plan for Improving Population Health - 2018	9
Access to Care	10
Diabetes	12
Tobacco Use	14
Obesity	16
Appendix: <i>Get Healthy Idaho - Measuring and Improving Population Health</i>	
Idaho Population Health Assessment Summary	19
Demographics and Social Determinants of Health	23
Idaho Public Health District Map	25
Leading Causes of Death	27
Years of Potential Life Lost Before Age 75	32
Idaho Leading Health Indicators	33
Idaho Health Professional Shortage Area Maps	69
Idaho County Population Density Map	72
Progress Report for 2017 Strategies and Measures	73
Progress Report for 2015 Strategies and Measures	79
Population Health Assessment Summaries	84
Acronyms	111



IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR

RUSSELL S. BARRON – DIRECTOR

ELKE SHAW-TULLOCH, MHS – ADMINISTRATOR

DIVISION OF PUBLIC HEALTH

Message from the State Health Official

Welcome to the *Get Healthy Idaho: Measuring and Improving Population Health!* *Get Healthy Idaho* consists of two integral parts: an annual plan to improve population health and an assessment of the current state of the health of Idahoans. *Get Healthy Idaho* is a five year plan and includes annual progress on the plan objectives. The 2018 plan priorities remain:

1. Access to Healthcare
2. Diabetes
3. Tobacco
4. Obesity

The *Get Healthy Idaho* assessment is the most comprehensive review of the health of Idahoans. This information provides the foundation for understanding the health of our residents and communities. In the 2018 plan you will see updated data tables, as well as new data collected from partners across the state. While the assessment highlights areas of particular concern, it also provides insight into the assets that exist across the state and within communities that can be used to address some of the areas of opportunities.

The Idaho Leading Health Indicators form the framework of *Get Healthy Idaho* and dovetail with the overarching Statewide Healthcare Innovation Plan (SHIP). The SHIP is a four-year (2015-18) statewide initiative testing a model to improve healthcare, improve health outcomes, and lower healthcare costs through primary care practice transformation into patient centered medical homes. Idaho's Leading Health Indicators focus the work and assure that a population health perspective is maintained that spans the life course.

Get Healthy Idaho is a key element in the Division's achievement of 5-Year accreditation status through the Public Health Accreditation Board. This status was awarded on June 6, 2017.

Get Healthy Idaho incorporates strategies that shift from traditional clinical based approaches, to innovative patient centered and community-wide approaches. The Division of Public Health makes every effort to integrate and collaborate within the Division and Department, as well as with external partners to maximize positive impacts to population health measures.

The Division of Public Health is committed to the comprehensive, inclusive, transparent, and on-going process of *Get Healthy Idaho* that supports the health of all Idahoans, both current and future. We thank you for your interest in this report and Idaho's future.

An electronic copy of this report as well as the most current population health data associated with *Get Healthy Idaho* can be found online at <http://gethealthy.dhw.idaho.gov>.

In Good Health!



Elke Shaw-Tulloch, MHS
Administrator
Division of Public Health

Introduction



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Introduction

Get Healthy Idaho: Measuring and Improving Population Health is an initiative of the Department of Health and Welfare (DHW), Division of Public Health (DPH) that consists of two integral parts: a statewide, comprehensive population health assessment that provides a foundation for understanding the health of Idahoans and communities; followed by a plan for improving population health that focuses public health efforts to address specific priority areas. The intended outcome of *Get Healthy Idaho* is to improve the health of all Idahoans through broader partnerships to deliver the outlined strategies.

Get Healthy Idaho supports the DPH Strategic Plan's central challenge - to advance the Division's leadership and influence in public health. It supports the identified priority areas of the Strategic Plan to strengthen public health practice and to ensure programmatic excellence. This work satisfies Public Health Accreditation Board (PHAB) standards 1.1 (statewide health assessment) and 5.2 (statewide health improvement plan). Additionally, the Statewide Healthcare Innovation Plan (SHIP) Model Test Grant requires the development and implementation of a population health improvement plan. *Get Healthy Idaho* serves dual roles to meet both the requirements of PHAB and the SHIP Model Test Grant. *Get Healthy Idaho* will be reviewed and updated annually from perspectives of both the data and the identified strategies.

The priorities identified in *Get Healthy Idaho* will help shape the focus of public health over the next four years, including priorities outlined in the SHIP and those identified by the *Get Healthy Idaho* population health assessment.

In the spring of 2015, the Population Health Work Group (PHWG) was formed as a workgroup of the Idaho Healthcare Coalition. This group serves a dual role of advancing the population health work of the SHIP and providing oversight and approval of the *Get Healthy Idaho* plan. The PHWG is chaired by the Division of Public Health Administrator, co-chaired by a local public health district director, and consists of leaders from local public health, statewide-community entities, and members of the Idaho Healthcare Coalition.

Get Healthy Idaho aligns with the calendar year. This was a purposeful decision to assure the most current information is available for the legislative session and to allow the DPH strategic plan and *Get Healthy Idaho* to have staggered timelines, allowing them to truly inform each other. The most current version of *Get Healthy Idaho* is made available in January through <http://gethealthy.dhw.idaho.gov>, the DHW website, or in hard copy through the DPH Administration.

Advancing Population Health

Community advisory groups called Community Health Outcome Improvement Coalitions (CHOICE), will play an important role in advancing population health within their region through the inclusion of constituents outside the traditional hospital and physician model but in partnership with the Regional Care Organization (RCO) and PCMH partners with which they are working. Traditional models of healthcare reform focus primarily on controlling the costs of care and improving patient's outcomes and experience. They tend to focus on clinical preventive services and may not address "up-stream" or higher-level determinants of health that often drive spending. Through this reform initiative we hope to broaden the traditional approach through the integration of clinical services, public health, and community based initiatives.

Knowing that a balanced portfolio of measures will include both clinical and community-wide measures CHOICE advisory groups may choose to be organized around the Centers for Disease Control and Prevention's (CDC) system for analyzing the measures of health at the patient level, clinic-community level and community-wide level. In their Community Channel activities CHOICE will be especially focused in the area of community-wide health as described below:



Traditional Clinical Approaches – The focus is on an individual and has a patient construct. Typical clinical services done in a one-on-one patient interaction would be at this level.



Innovative Clinical Care – The focus is a patient construct with a narrow population view such as a practice or an accountable care organization. The patient centered medical home is an innovative clinical mode that provides linkages which support patients in the community.






Community-wide Health – The focus is on a broad population, such as a Health District or the state of Idaho, and has a community construct. Community-wide health initiatives typically have a policy focus.



St. Maries, Idaho Middle School STAND grant assists with smoke free ordinance for a local park.
American Lung Association – Support Teens Against Nicotine Dependency (STAND)

The following table defines these three levels of services and includes disease and risk factor examples.

Traditional Clinical Approaches 	Innovative Clinical Care Patient-Centered Medical Home 	Community-wide Health 
Focused on an individual; patient construct		Focused on a broad population; community construct
Typical clinical services done in a one-on-one patient interaction	Linkages that support patients in the community and that provide services outside the clinical setting	Broader, mostly policy focused aimed at supporting the broad community and the overall health of the population in the community
DIABETES Example		
Screening for pre-diabetes, diagnosis, treatment, medication, clinical guidance, A1C monitoring, eye exam, foot exam	Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietitian-Nutritionist referral, dental referral, CHW or CHEMS support for blood sugar monitoring and medication management	Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; policies to reduce tobacco usage and trans fats in foods
OBESITY Example		
Diagnosis, medication, weight and height to calculate body mass index and monitor, blood pressure, cholesterol screening, physician/patient counseling	Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietician-Nutritionist referral, dental referral and cavity risk assessment, CHW or CHEMS support for blood sugar monitoring and medication management	Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; mandatory changes in school vending and physical education courses
TOBACCO Example		
Screening patients for smoking, ensuring smoking cessation referral, physician/patient counseling	Linkages that support patients in community or medical-health neighborhood, linking patient to cessation class or quit line	Practices and policies that support lower smoking rates statewide (clean indoor air policies, increasing the legal age of tobacco purchase, tobacco tax increase, etc.)

Statewide Healthcare Innovation Plan (SHIP)

SHIP is a national undertaking by the Center for Medicare and Medicaid Innovation (CMMI) to redesign the healthcare delivery and payment system and create new models of care. In Idaho, the goal of the SHIP is to redesign the healthcare system, evolving from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes. The foundational goals include increasing access to coordinated care among primary care providers; transforming primary care practices into patient-centered medical homes, and creating the broader medical-health neighborhood, including public health, behavioral health, community services, housing, social services, and more, that provide the wrap-around community level support to achieve better health outcomes and wellness. Idaho received a CMMI Model Test Grant to implement the SHIP. This grant is administered by the Department of Health and Welfare, but advised by the Governor-appointed Idaho Healthcare Coalition (IHC). Public health is central to these efforts and leads the seven Regional Health Collaboratives (RCs) which are created to locally support provider practices as they transform into patient centered medical homes and address regional population health issues.

A requirement of CMMI model test grant is the development and implementation of a population health improvement plan focused on the three priority areas of:

1. Comprehensive Diabetes Care
2. Obesity in Children
3. Tobacco Cessation Intervention



Plan for Improving Population Health



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Get Healthy Idaho

Plan for Improving Population Health, 2018

The results of the new population health assessment and the ongoing requirements of the SHIP-Model Test Grant support the continued focus on the following four health priorities in 2018:

1. Access to Care
2. Diabetes
3. Tobacco
4. Obesity

The *2018 Get Healthy Idaho* contains goals, objectives, strategies, and measures for each of the above priority areas. The *2018 Get Healthy Idaho*, which builds on the first two years, can be found on the following pages (10-17).

A report providing the status of the work completed to date in each priority area can be found beginning on page 73.



Health Priority: ACCESS TO CARE

Five Year Goal: Increase access to healthcare services

SMART Objective(s): Annually assess 100% of Health Professional Shortage Areas due for review

Increase to 50, the number of PCMHs that adopt an element of the virtual PCMH by January 2019

Strategy 1: Review and renew healthcare shortage areas to maximize funding and healthcare provider recruitment efforts in rural and frontier counties.

Activities:

The DPH's Bureau of Rural Health and Primary Care actively collects and analyzes data to support federally-designated Health Professional Shortage Areas in primary care, dental health, and mental health and Medically Underserved Areas/Populations. These designations help improve healthcare access through new and expanded resources.

Measure 1:

Number of currently designated areas reviewed annually as dental, mental, primary care Health Professional Shortage Areas

Baseline

46 per year

Annual Target

46

Strategy 2: Develop and implement virtual patient-centered medical homes (PCMH) through Community Health EMS (CHEMS), community health workers (CHW), and Telehealth.

Activities:

The DPH's Bureau of Rural Health and Primary Care and Bureau of Emergency Medical Services (EMS) and Preparedness provide training, resources, and mentoring to establish new CHEMS programs statewide.

The Bureau of Rural Health and Primary Care also provides access to CHW training as well as resources to establish new telehealth programs.

The CHEMS, CHW, and telehealth programs are designed to extend the reach of primary care in rural, frontier, and underserved communities and are referred to as virtual patient-centered medical homes in SHIP.

Measure 1:

Number of Idaho EMS agencies recruited to participate in the CHEMS initiative

Baseline

2
(CY2015)

Target

13

Measure 2:

Number of Idaho EMS agencies providing CHEMS services

Baseline

1
(CY2015)

Target

13

Measure 3:

Number of CHWs trained through Idaho State University program

Baseline

0
(CY2015)

Target

75

Measure 4:

Number of telehealth programs established in PCMHs

Baseline

0
(CY2015)

Target

12

Strategy 3: Recruit new and existing PCMHs to participate in the SHIP.**Activities:**

The DPH, in partnership with the local Public Health Districts (PHDs) and through the SHIP Model Test Grant, actively supports the development of PCMHs and Regional Health Collaboratives (RCs). These efforts include subgrants to PHDs for leadership, quality improvement, transformation support to primary care clinics to become PCMHs, and convening of the RCs.

Measure 1:	Baseline	Annual Target
Number of primary care clinics recruited to participate in the SHIP PCMH transformation	13 (CY2015)	55
Measure 2:	Baseline	Target
Number of RCs	0 (CY2015)	7

Idaho's Challenges and Opportunities: Access to Care

Idaho is the 11th largest state in the nation and 39th in population size with 1,683,140 people based on the 2016 census estimates. The state's per capita income is significantly less than the national average (\$24,280 compared to \$29,829), while the percentage of persons living in poverty is 14.4% for Idaho compared to the U.S. rate of 12.7%.

The Idaho Department of Commerce defines rural as any county that does not have a population center with 20,000 persons or greater, this definition includes 35 of Idaho's 44 counties. Eighteen of Idaho's 44 counties or approximately 40% are defined as frontier counties (fewer than 6 people per square mile, National Center for Frontier Communities).

Using 2013 data from U.S. Department of Health and Human Services, CQ Press ranks Idaho 13th nationally in percentage of population lacking access to primary care services at 17.4%, 6.5% greater than the national average (SAGE Publications, Inc., 2013). Idaho also ranks 48th out of 50 states with 70 physicians per 100,000 population according to CQ Press, well under the national rate of 98 physicians per 100,000 population (SAGE Publications, Inc., 2012).

Primary Care: There are 43 Health Professional Shortage Area (HPSA) designations for geographic areas and population groups across the state of Idaho. These designations cover 96.4% of the state's total land area: approximately 60.5% of Idaho's geography is designated as a population group HPSA, while 35.8% is designated as a geographic HPSA in the primary care discipline.

Dental Health: There are 43 HPSA designations for geographic areas and populations across the state of Idaho. These designations cover a total of 97.0% of the state's land area: approximately 78.2% of Idaho's geography is designated as a population group HPSA, while 18.8% is designated as a geographic HPSA in the dental discipline.

Mental Health: There are 7 HPSA designations, which encompass all 44 counties, for geographic areas and populations across the state of Idaho. Due to the severe shortage of mental health professionals across the state, the Idaho Primary Care Office reviews the state's geography on a regional basis. As a geographic HPSA, these mental health designations encompass 100% of Idaho's land area and population.

Health Priority: DIABETES

Five Year Goal: Reduce the economic burden of diabetes in Idaho and improve the quality of life for those who have or are at risk for diabetes

SMART Objective: Increase from 51 to 55 the availability of educational opportunities for Idahoans to manage modifiable risk factors associated with diabetes or pre-diabetes by July 2018

Strategy 1: Increase the number of CDC-recognized Diabetes Prevention Programs (DPP) and American Diabetes Association (ADA) or American Association of Diabetic Educators (AADE) Diabetes Self-Management Education (DSME) Programs.

Activities:

Idaho Diabetes Prevention and Control Program (DPCP) contracts with the local Public Health Districts to develop an alternative location for delivery of DSME appealing to both patients and referring providers (e.g. churches, community centers, libraries, etc.).

The DPCP works with healthcare systems to increase the number of trained primary care staff who complete the American Association of Diabetes Educators (AADE) Level 2, or comparable AADE diabetes training specific to their position to enhance diabetes outcomes and promote the benefits of patient participation in ADA/AADE DSME Programs as appropriate.

The DPCP works with the DHW media contractor to create and implement a diabetes and pre-diabetes marketing plan and campaign to reach Idaho adults with diabetes or who are at high-risk for diabetes. The program also works with healthcare providers connecting them with local ADA/AADE DSME and CDC-recognized or pending recognized DPPs.

Measure 1: Number of ADA-recognized/AADE-accredited DSME programs	Baseline	Annual Target
	28 (SFY2015)	42
Measure 2: Number of persons with diabetes who have at least one encounter at an ADA recognized/AADE accredited program.	Baseline	Target
	6,412 (CY2012)	8,400

Strategy 2: Increase referrals to CDC-recognized Diabetes Prevention Programs and ADA/AADE Diabetes Self-Management Education Programs.**Activities:**

The DPCP contracts with the local Public Health Districts to implement standardized referral processes to DSME and DPPs, and work with local healthcare clinics to promote the adoption of American Medical Association/ CDC provider toolkit.

The DPCP contracts with two Tribal Health Centers in Idaho to establish standardized referrals to DSME and DPP.

The DPCP contracts with healthcare systems to establish standardized referral systems for newly diagnosed pre-diabetic patients to CDC-recognized or pending recognition DPPs in Idaho.

The DPCP continues to partner with Health Matters and DPP lifestyle coaches in each of the local Public Health Districts to enroll state employees in new classes and obtain aggregate data.

The DPCP contracts with local DPPs to increase access and awareness of the National Diabetes Prevention Program.

The DPCP works with Idaho's Quality Improvement Network, Qualis, to establish a standardized cross-referral process between existing Chronic Disease Self Management P/DSMP programs and ADA/AADE DSME programs.

Measure 1:	Baseline	Annual Target
Number of persons with pre-diabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized DPP	89 (SFY2014)	320
Measure 2:	Baseline	Target
Number of CDC-recognized or pending recognition DPPs	3 (SFY2015)	15

Idaho's Challenges and Opportunities: Diabetes

Effectively managing diabetes will help Idahoans living with diabetes lead more productive and healthier lives. An estimated 110,000 Idaho adults, or 9% of the adult population, live with diabetes. CDC estimates that 560,000 Idaho adults, or 35% of the adult population, live with pre-diabetes. Diabetes is the seventh leading cause of death in Idaho and about one third of Idaho adults living with diabetes do not know they have the disease. The direct medical cost of diagnosed cases of diabetes in Idaho is estimated as more than \$172 million annually. Improperly managed diabetes often leads to costly diabetes related complications and has a tremendous impact on Idaho's Medicaid program as well as other Idaho health insurers. Most diabetes can be prevented or delayed if a range of risk factors is eliminated particularly physical inactivity, unhealthy diet, tobacco use, and alcohol misuse. Numerous studies demonstrate that diabetes treatments and therapies improve diabetes control and reduce the incidence of complications due to diabetes. With affordable access to evidence-based, community-based diabetes prevention programs many people with pre-diabetes can prevent or significantly delay the onset of type 2 diabetes. With proper management and treatment, individuals with diabetes can live healthy, productive lives.

Health Priority: TOBACCO USE

Five Year Goal: Reduce tobacco use in Idaho

SMART Objective(s): Increase the percentage of Idaho adult smokers that have attempted to quit smoking in the past 12 months from 57.6% to 60.0% by July 2018.*

Strategy 1: Increase referrals to cessation services.		
<p>Activities:</p> <p>The DPH's Women's Health Check Program (WHC) contracts with local Public Health Districts and health systems to provide training at all enrollment sites to ensure WHC clients are assessed for tobacco use annually and are referred to tobacco cessation resources, as appropriate.</p> <p>Project Filter, Idaho's Tobacco Prevention and Control Program, contracts with the seven local Public Health Districts to provide technical assistance, including training in QuitLine referrals, to healthcare sites.</p> <p>Project Filter developed and implemented a campaign directed at healthcare systems promoting referrals to the Idaho QuitLine, an evidence-based cessation service.</p> <p>Note: Quitline services include both telephonic and online services free of charge, including nicotine replacement therapy.</p>		
Measure 1: Number of women enrolled in WHC ages 21-64 referred to the QuitLine cessation services. Note: Target is lower than baseline due to decreased enrollment for Women's Health Check services.	Baseline	Annual Target
	708 (SFY2014)	700
Measure 2: Number of tobacco users who registered for Idaho QuitLine cessation services.	Baseline	Annual Target
	8,142 (SFY2015)	8,956 (10% above baseline)
Strategy 2: Promote the use of Nicotine Replacement Therapy (NRT) for appropriate individuals enrolled in cessation services.		
<p>Activities:</p> <p>Project Filter developed a healthcare provider "toolkit" with information about referral and cessation resources, including the efficacies of NRT use during a quit attempt. To date, just over 100 toolkits have been distributed to Federally Qualified Health Centers and to private health systems.</p>		
Measure 1: Number of Idaho QuitLine registrants shipped at least 4 weeks of NRT	Baseline	Annual Target
	5,943 (SFY2015) (73% of total registrants)	6,717 (75% of target for phone and QuitLine)
Measure 2: Proportion of registrants ordering NRT through Idaho QuitLine cessation services	Baseline	Target
	73% (SFY2015)	75%

*Baseline estimate of 57.6% is based on 2014 Idaho Behavioral Risk Factor Surveillance System (BRFSS) survey. Objective is unmet at time of publication based on results of 2016 Idaho BRFSS survey (52.8%).

Idaho's Challenges and Opportunities: Tobacco Use

Tobacco use is the single most preventable cause of disease, disability and death in the United States, resulting in an estimated 480,000 people dying prematurely from smoking or exposure to secondhand smoke (U.S. Department of Health and Human Services, 2014). Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined. Comprehensive strategies have been identified and proven effective for preventing youth from starting, helping smokers quit, and reducing secondhand smoke exposure, making the fight against tobacco use a winnable battle. High tobacco taxes, smoke-free or tobacco-free policies, well-funded youth prevention programs and regulation of tobacco products are proven ways to reduce death and disease caused by tobacco use. Tobacco use remains the leading preventable cause of death and disease in Idaho. Idaho's most recent (2016) Behavioral Risk Factor Surveillance Survey (BRFSS) indicates the current smoking rate for adults is 14.5%. While this is lower than the national average of 15.1%, there is still work to be done. Data from the 2015 Idaho Youth Risk Behavior Survey (YRBS) show the Idaho youth smoking rate to be 9.1% and that nearly 14.3% of Idaho youth are currently using electronic nicotine delivery systems. The economic burden incurred in Idaho from smoking has reached \$508 million in total medical costs (\$100.5 million covered by Medicaid) and \$433.9 million in lost productivity from premature death each year (CDC, 2014). This amount does not include health costs caused by exposure to secondhand smoke, smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking. Tobacco use also imposes additional costs such as workplace productivity losses and damage to property. Despite a continued focus on eliminating tobacco-related health disparities, the prevalence of tobacco use and subsequent health consequences continue to disproportionately impact specific populations. American Indians/Alaskan Natives, Hispanics and Latinos, the lesbian, gay, bisexual, transgender (LGBT) community, those of low socio-economic status, those living with mental illness, Medicaid enrollees, and veterans represent Idaho population groups that experience tobacco-related health disparities.



Health Priority: OBESITY

Five Year Goal: Reduce the burden of obesity in Idaho

SMART Objective(s): Decrease the percentage of children age 10-17 who are overweight or obese from 27.8% to 26.8% by December 2018*

Strategy 1: Increase healthy options for infants and children through awareness, education, and collaboration.

Activities:

The DPH's Idaho Physical Activity and Nutrition (IPAN) Program contracts with the local Public Health Districts to provide in-person Let's Move! Child Care (LMCC) trainings and to distribute Color Me Healthy toolkits to all providers who participate in the training. In addition, IPAN works with the Idaho STARS Program to provide online LMCC modules for childcare providers to take on their own time.

The DPH's Idaho Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program contracts with local entities to provide group classes or group events related to meal planning, cooking skills, healthy eating, and age-appropriate healthy nutrition and physical activity counseling. In addition, the Idaho WIC program provides local WIC Programs with the complete series of online learning modules describing baby behaviors which could influence a mother's feeding choice and help her to understand the needs of the baby in regards to stimulation, engagement, disengagement, and development.

Measure 1: Number of childcare providers who have participated in Let's Move trainings	Baseline	3 Year Cumulative Target
	110 (SFY2015)	280
Measure 2: Number of childcare providers that develop an action plan to improve nutrition	Baseline	3 Year Cumulative Target
	80 (SFY2015)	200
Measure 3: Percentage of children on WIC age 2-5 who are overweight or obese	Baseline	Annual Target
	28.1% (SFY2016)	26%
Measure 4: Percentage of women on WIC who are still breastfeeding at 3 months	Baseline	Target
	53.6% (SFY2016)	55%
Measure 5: Percentage of 3rd grade students who are overweight or obese based on BMI	Baseline	Target
	29.7% (2011-12)	26%

Youth overweight and obesity is defined on pages 35 and 36

Adult overweight and obesity is defined on pages 37 and 38

*Baseline estimate of 27.8% is based on 2011/12 National Survey of Children's Health. The objective is currently met based on results of 2016 Idaho National Survey of Children's Health (26.0%). This objective will be tracked through the remainder of the population health improvement plan timeframe (2015-2019).

Idaho's Opportunities and Challenges: Obesity

Idaho, like most states, is seeing a steady increase in the percentage of its population that is overweight or obese. Overweight and obesity are both labels for ranges of weight that are excessive for a certain height. Due to the difficulty of measuring body fat directly, overweight and obesity are estimated by body mass index (BMI). Adults with a BMI between 25.0 and 29.9 are considered overweight and those with a measure of 30 and greater are considered obese. Childhood and adolescent BMI measures take sex and age into consideration. Most obesity data for adults is self-reported through the BRFSS. According to the 2016 BRFSS, the majority of Idahoans ages 18 and older are considered overweight or obese (64.5%). The breakout is 37.1% overweight and 27.4% obese. Across Idaho, males are more overweight than females (72.1% compared with 56.6%) and more obese than females (28.1% compared with 26.6%). Hispanic adults are more overweight or obese than non-Hispanic adults (69.8% compared with 64.1%). Overall, Idaho children are less overweight or obese than national rates (26.0% vs. 31.3%). The current obesity rate for Idaho High School students is 11.1%. Idaho schools are not required to collect height and weight data or report BMI. During the 2016-2017 school year, the Division's Bureau of Community and Environmental Health (BCEH) conducted the Idaho 3rd Grade BMI Assessment. That assessment found 28.6% of 3rd graders to be overweight or obese. Childhood overweight and obesity rates range from 10 to 50 percent in communities across Idaho. Many of the leading causes of preventable disease and death, including heart disease, stroke, type 2 diabetes and certain types of cancer are obesity related. A 2012 Robert Wood Johnson Foundation Trust for America's Health Report estimated that Idaho spends more than \$2.7 billion in costs due to obesity, which are projected to rise to more than \$3 billion by 2030. The Report also estimates that a five percent decrease in obesity would save Idaho \$1.2 billion by 2020 and \$3.3 billion by 2030.

An early and effective intervention to promote the healthy weight of children is breastfeeding. Prolonged breastfeeding has been shown to decrease the risk of overweight in children (<http://pediatrics.aappublications.org/content/113/2/e81.short>). Breastfeeding longer than six (6) months postpartum provides several health benefits to both the infant and the mother. Typically, during the time period after the birth of the infant up to three (3) months postpartum is when women tend to stop breastfeeding. There are several factors that impact the decision to stop breastfeeding. However, with focused support during this critical period, many women can be encouraged to continue to breastfeed. While Idaho generally has good breastfeeding rates, improving in this area can have multiple and long-term benefits for both mothers and children. Continued education and policy efforts physical activity, nutrition, and the built environment will be critical in reducing obesity and improving health across the lifespan.



Population Health Assessment



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Appendix: 2017 Health Assessment

Idaho Population Health Assessment Summary

Introduction

The DPH's strategic plan illustrates the Division's commitment to advancing the Division's leadership and influence in public health in Idaho. To accomplish this goal, the DPH is committed to working closely with partners, both within the Idaho Department of Health and Welfare and across the state, to better understand the health issues of Idahoans, the underlying factors that impact health, and the resources and gaps that provide a wealth of untapped opportunity.

The population health assessment is the most comprehensive assessment of the health of Idahoans. With the completion of the five year assessment and ensuing annual review and update, the DPH maintains a current view of the health of Idahoans and the continued areas of progress and deficiencies. The *Get Healthy Idaho: Measuring and Improving Population Health*, provides the road map.

Assessment Process Overview

Two frameworks provide structure and guidance to the assessment process: "The Community Health Assessment Toolkit," published by the Association for Community Health Improvement and the "Planning and Conducting Needs Assessments: A Practical Guide," by Wilkin and Altschuld.

For the first health assessment, completed in 2015, community level data in the format of local public health and hospital health needs assessments, available between June and October of 2014, were collected and analyzed (using primarily qualitative methods). Information from these assessments was compiled to align with the seven local Public Health District geographic areas. Additionally, the DPH identified other health assessments currently underway that complement the health needs assessments. These assessments included the Maternal and Child Health Five Year Needs Assessment and the Primary Care Needs Assessment. The national Public Health Accreditation Board (PHAB) standards also informed the data refining process. PHAB identifies what it considers core public health programs and, as data were assessed, only data that fell within the framework of PHAB were prioritized to move forward for consideration in the health improvement plan.

As part of the DPH's annual data assessment and review, health assessments were conducted in the fall of 2016 and 2017 among members of the Population Health Work Group (PHWG). The assessments were administered via an online survey tool and focused on questions from the 2014 population health needs assessments seeking data about health priorities at the local level including new concerns, gaps, assets, and resources. A Population Health Assessment Survey link was sent out to individual PHWG members and key partners with a request to forward the survey link to anyone else who might contribute to the health assessment. There were 18 completed surveys collected in 2016 and 12 completed surveys collected in 2017. Responses were integrated with the 2015 results to help identify public health priorities and strategies. The most recent information was shared with the PHWG in November, 2017.

The results of the 2015, 2016, and 2017 assessments are included in tables at the end of this report (beginning on page 85).

Summary of Findings

The following priority health issues were identified by the health assessment respondents as priority health issues, with the 10 highest priorities among all of the responses listed here (highest priority listed at the top with number of references in 2015, 2016, and 2017 combined):

- Obesity (23)
- Tobacco Use (23)
- Diabetes (21)
- Mental Health/Behavioral Health (20)
- Suicide (15)
- Physical Activity (15)
- Cardiovascular Health (15)
- Access to Care/Uninsured (15)
- Substance Abuse (15)
- Nutrition/Food Insecurity (12)

Among the top health priorities it is important to note that Suicide and Mental Health/Behavioral Health are often referred to as a single issue, and if combined, would top the list of health priorities by a significant margin. Although neither of the two health issues have been selected as priority health areas for Idaho's health improvement focus, it is important to note the support that is growing in this area. During the 2016 Idaho Legislative session, approval for the creation of a statewide Suicide Prevention Program was passed and the Idaho Suicide Prevention Program was staffed and operating beginning July 1, 2016. There continues to be legislative support for Crisis Centers across the state. The SHIP efforts also focus on integrating behavioral health with primary care statewide.

The master list of priority health issues identified in assessments conducted in 2015, 2016, and 2017 include: Access to Care/Uninsured, Alcohol, Asthma, Alzheimer's Disease, Behavioral Health, Cancer, Cardiovascular Diseases (Heart Disease and Stroke), Chronic Disease, Diabetes, Early Childhood Care, Exercise/Physical Inactivity, Food Insecurity, Immunization, Maternal/Infant/Child Health, Nutrition, Obesity and Overweight, Oral Health, Physical Activity, Prenatal Care, Senior Health, Sexually Transmitted Diseases, Substance Abuse, Suicide, Tobacco Use, Unintentional Injury, and Vaccine Preventable Diseases.

Managing Performance

The *Get Healthy Idaho* process includes quarterly reporting on progress toward identified measures and annual ongoing review of data. *Get Healthy Idaho* activities, assessment data, or both are consistent agenda items at meetings of the PHWG. At least annually one PHWG meeting is dedicated to: 1) reviewing the status of the current population health assessment and improvement plan, 2) discussing new and emerging health issues from both state and local perspectives, and 3) having an active and engaged dialogue among partners. The annual meeting is an opportunity for partners to provide input on what is working and what is not, to share their perspectives, and guide the creation of goals for the coming year. At this meeting, an update on the Idaho Leading Health Indicators and the identified priorities of *Get Healthy Idaho* are discussed. Partners are updated on work that has been achieved and work that is planned. Partners contribute to the assessment of new assets and resources and identify emerging issues that may be part of future improvement plans.

Assessment Content:

Data collected and reviewed for the population health assessment came from a number of sources. The following sections include detail on the data reviewed:

- **Demographics and Social Determinants of Health**

These provide an overview of demographic and other issues that impact health.

- **Leading Causes of Death**

The Leading Causes of Death section presents the leading causes in rank order for the state and then by sex and age. Data on years of potential life lost are also presented.

- **Idaho Leading Health Indicators**

Idaho's Leading Health Indicators (LHIs), developed by the DPH, provided the framework for the core data of the assessment. The LHIs offer a consistent approach to assess the health of Idahoans and provide a way to determine if health status is changing and/or improving over time. The 2018 assessment includes an update of the LHIs with a redesign of the data pages providing more effective visualization of the data.

- **Health Professional Shortage Area Maps**

These maps depict the most recent data on health professional shortage areas for primary care, mental health, and dental health. A population density map is also presented.



Demographics and Social Determinants



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Demographics and Social Determinants of Health

Idaho is a large western state with impressive mountain ranges, large areas of high desert and massive expanses of forested terrain. Idaho contains the second largest wilderness area in the lower 48 states, the Frank Church – River of No Return Wilderness, which covers almost 2.4 million acres. Geography and distance impact both the demographic characteristics and social determinants of health within Idaho. Idaho is ranked 39th of the 50 United States for total population and 14th for geographic size. The 2016 estimated population for Idaho was 1,683,140 and because of its large size and relatively small population, Idaho remains one of the most rural states in the nation. With approximately 19.0, people per square mile Idaho ranks 44th of the 50 states in population density. The national average population density is 87.4 people per square mile, a four-fold greater density than Idaho. Thirty five of Idaho's 44 counties are rural with 19 of these considered frontier, having fewer than six people per square mile.

The racial groups that comprised Idaho's population in 2016 were: (a) white, 93.3%; (b) black, 0.8%; (c) American Indian/Alaska Native, 1.8%; and (d) Asian or Pacific Islander, 1.7%. It is estimated that 2.4% of Idahoans identify as being of two or more races. Persons of Hispanic or Latino origin comprised 12.3% of Idaho's total population (US Census Bureau). Idaho is home to six federally recognized tribes: Coeur d'Alene Tribe, Kootenai Tribe of Idaho, Nez Perce Tribe, Shoshone-Bannock Tribes, the Northwestern Band of the Shoshone Nation, and the Shoshone-Paiute Tribe. Idaho also has two refugee centers located in Ada County in southwest Idaho and Twin Falls County in south central Idaho.

The conditions which people are born, live, learn, work, and play have a substantial impact on health outcomes. These conditions, known as the social determinants of health, are important to consider when thinking about improving the health of a population. They vary at every stage of life and include factors such as age, personal behaviors, socioeconomic status, educational attainment, employment status, the physical environment, and access to care. While these social determinant measures are not included within this report, many of the measures are available online at: <http://gethealthy.dhw.idaho.gov>.

According to the U.S. Census 2016 Current Population Survey, 14.4% of Idahoans were living below the poverty level and the median household income in Idaho is \$49,174. Idaho's per capita income in 2016 was \$23,807. Idaho is an important agricultural state, producing nearly one-third of the potatoes grown in the United States. Wheat, sugar beets, and alfalfa hay are also major crops. Other industries contributing to Idaho's economy include information technology, mining, lumber, tourism and manufacturing.

The most recent national data (2015) indicate that the percentage of Idahoans over the age of 25 who have graduated from high school is higher than the national average (90.0% and 87.1%, respectively). However, college attendance rates are among the nation's lowest with 44% of Idaho's 2014 high school graduates enrolled in a two- or four-year college (National Center for Higher Education Management Systems, 2016). A quarter (26.2%) of Idahoans over the age of 25 hold a bachelor's degree or higher, compared with the national average of 30.3%.

To facilitate the availability of public health services, contiguous counties in Idaho have been aggregated into seven public health districts (see map on next page). These seven areas are defined by geographic barriers as well as transportation routes and population centers. As reflected in the priorities, access to healthcare and other services have been identified as barriers to improving health outcomes for Idaho residents.

Idaho does not have a private or public medical or osteopathic school within the state for the training and development of physicians. In 2016, 100% of Idaho was a federally-designated mental health professional shortage area, 96% of Idaho was a federally-designated shortage area in primary care, and 97% of Idaho was designated a dental health professional shortage area. Idaho had 73.1 primary care physicians per 100,000 population in 2016 (2017 State Physician Workforce Data Book: Idaho Physician Workforce Profile. Washington DC: Association of American Medical Colleges, Center for Workforce Studies, Dec 2017.). In 2017, the Idaho Hospital Association membership directory reported 48 member hospitals (this includes one in Ontario, Oregon and one in Clarkston, Washington). Twenty-seven of these hospitals are

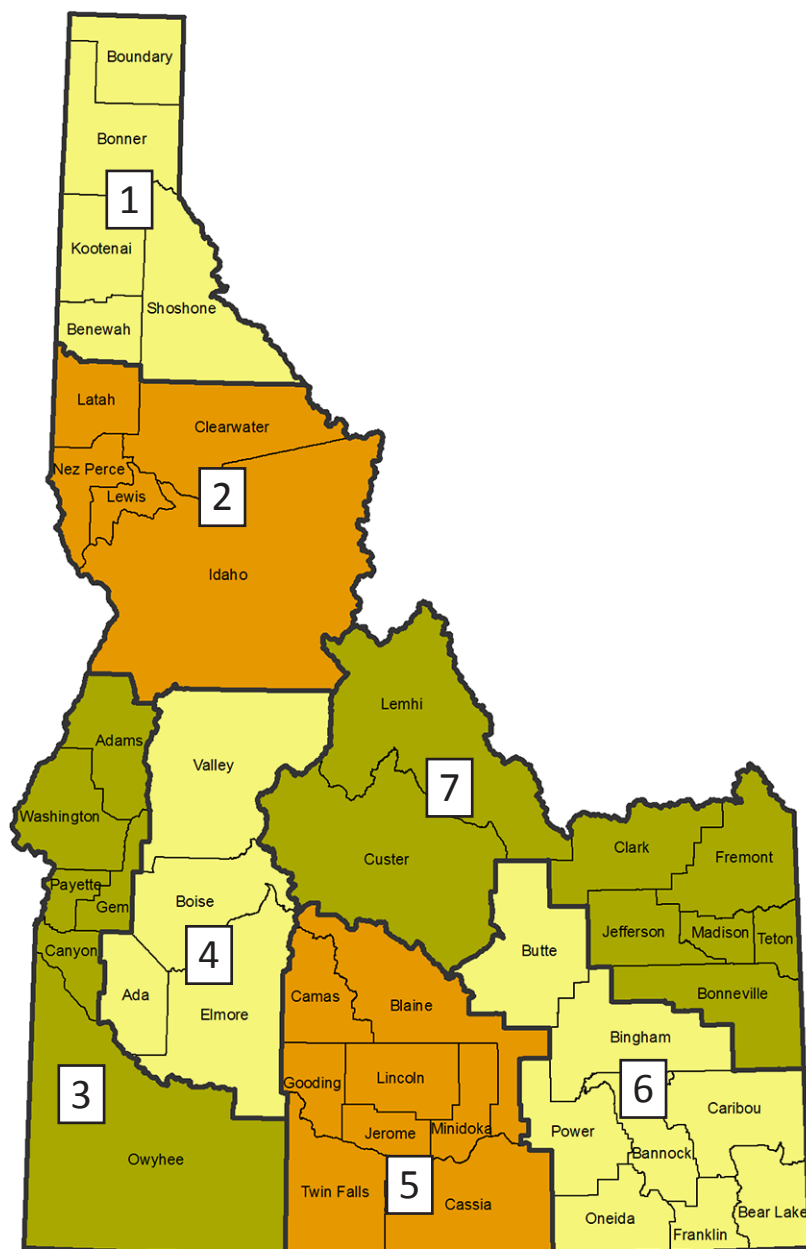
critical access hospitals, owning fifty-five clinics. These clinics include primary care and specialty services and may be co-located with the hospital as well as remote clinics.

Idaho Medicaid enrollment averaged 288,291 participants per month in State Fiscal Year (SFY) 2016 (July-June), an increase of 4% from SFY2015. The rate of growth declined slightly when compared to the Medicaid growth experienced during the peak of the recession and is now more closely approaching a growth pattern for a normal economy. The enrollment increase in SFY2014 can be attributed primarily to the Affordable Care Act (ACA) requiring people to have insurance coverage. Once past the ACA enrollment period, Idaho expects to return to a 2% to 3% enrollment growth rate (Facts, Figures and Trends 2016-2017, Idaho Department of Health and Welfare); however, recent changes in federal mandates will likely further impact insurance coverage enrollment.

In November of 2014, Your Health Idaho began operating as Idaho's fully state-based health insurance marketplace. For the 2016 coverage year, Idaho was second in the nation for the number of residents (per capita) who selected health insurance plans just behind Florida (State of Idaho, Your Health Idaho), and final enrollment numbers for Idaho in 2017 are expected to be even greater than 2016.



Idaho Public Health District Map



Panhandle Health District	Pubic Health - Idaho North Central District	Southwest District Health	Central District Health Department	South Central Public Health District	Southeastern Idaho Public Health	Eastern Idaho Public Health
PHD 1	PHD 2	PHD 3	PHD 4	PHD 5	PHD 6	PHD 7
Benewah Bonner Boundary Kootenai Shoshone	Clearwater Idaho Latah Lewis Nez Perce	Adams Canyon Gem Owyhee Payette Washington	Ada Boise Elmore Valley	Blaine Camas Cassia Gooding Jerome Lincoln Minidoka Twin Falls	Bannock Bear Lake Bingham Butte Caribou Franklin Oneida Power	Bonneville Clark Custer Fremont Jefferson Lemhi Madison Teton

Leading Causes of Death



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Leading Causes of Death

Leading Causes of Death to Idaho Residents Cause-Specific Crude and Age-Adjusted Rates, 2016 Idaho and 2015 U.S.

Cause of Death (Ranked for Idaho)	Deaths		Death Rates ¹			
			Crude		Age-Adjusted ²	
	Number	Percent	Idaho ³	U.S. ⁴	Idaho ³	U.S. ⁴
ALL CAUSES	13,370	100.0%	794.3	844.0	725.2	733.1
1. Diseases of heart	2,974	22.2%	176.7	197.2	160.2	168.5
2. Malignant neoplasms (cancer)	2,890	21.6%	171.7	185.4	151.2	158.5
3. Chronic lower respiratory diseases	864	6.5%	51.3	48.2	45.6	41.6
4. Accidents (unintentional injury)	847	6.3%	50.3	45.6	49.5	43.2
5. Cerebrovascular diseases	679	5.1%	40.3	43.7	37.0	37.6
6. Alzheimer's disease	606	4.5%	36.0	34.4	33.8	29.4
7. Diabetes mellitus	379	2.8%	22.5	24.7	20.0	21.3
8. Intentional self-harm (suicide)	351	2.6%	20.9	13.7	21.4	13.3
9. Influenza and pneumonia	204	1.5%	12.1	17.8	11.1	15.2
10. Chronic liver disease and cirrhosis	190	1.4%	11.3	12.5	9.9	10.8
11. Nephritis, nephrotic syndrome & nephrosis	188	1.4%	11.2	15.5	10.2	13.4
12. Parkinson's disease	166	1.2%	9.9	8.7	9.3	7.7
13. Essential hypertension & hypertensive renal disease	106	0.8%	6.3	10.0	5.8	8.5
14. Septicemia	100	0.7%	5.9	12.7	5.4	11.0
15. Pneumonitis due to solids and liquids	98	0.7%	5.8	6.2	5.3	5.3
All other causes	2,728	20.4%	NA	NA	NA	NA

1. Rates are per 100,000 population. NA = not applicable. Rates are not applicable for all other causes.

2. Age-adjusted rates are artificial measures developed to eliminate the bias inherent in differing age compositions, thus allowing comparisons between geographic regions. Idaho and U.S. age-adjusted rates were calculated using the 2000 U.S. population estimate as the standard population.

3. Idaho rates are based on the July 1, 2016 population estimates.

4. Source U.S. crude and age-adjusted rates: Centers for Disease Control and Prevention, the National Center for Health Statistics. Rates are calculated using the 2010 Census provided by the U.S. Bureau of the Census.

Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2017.

Leading Causes of Death to Idahoans by Sex
Cause-Specific Crude and Age-Adjusted Rates, 2016 Idaho and 2015 U.S.

Males						
Cause of Death (Ranked for Idaho)	Deaths		Crude		Age-Adjusted ²	
	Number	Percent	Idaho ³	U.S. ⁴	Idaho ³	U.S. ⁴
ALL CAUSES	6,938	100.0%	822.5	868.0	826.2	863.2
1. Diseases of heart	1,652	23.8%	195.8	211.7	199.3	211.8
2. Malignant neoplasms (cancer)	1,533	22.1%	181.7	198.3	173.2	189.2
3. Accidents (unintentional injury)	519	7.5%	61.5	58.7	63.6	58.7
4. Chronic lower respiratory diseases	418	6.0%	49.6	45.8	49.4	46.0
5. Cerebrovascular diseases	314	4.5%	37.2	36.8	38.3	37.8
6. Intentional self-harm (suicide)	268	3.9%	31.8	21.5	32.5	21.1
7. Diabetes mellitus	210	3.0%	24.9	27.3	24.1	26.2
8. Alzheimer's disease	174	2.5%	20.6	21.3	23.3	23.7
9. Chronic liver disease and cirrhosis	122	1.8%	14.5	16.2	12.6	14.5
10. Parkinson's disease	103	1.5%	12.2	10.7	13.2	11.6
11. Nephritis, nephrotic syndrome & nephrosis	99	1.4%	11.7	16.1	11.8	16.3
12. Influenza and pneumonia	80	1.2%	9.5	17.0	9.8	17.7
13. Pneumonitis due to solids and liquids	52	0.7%	6.2	6.9	6.7	7.3
14. Septicemia	48	0.7%	5.7	12.3	5.7	12.1
15. Essential hypertension & hypertensive renal disease	46	0.7%	5.5	8.8	5.7	8.8
All other causes	1,300	18.7%	NA	NA	NA	NA

Females						
Cause of Death (Ranked for Idaho)	Deaths		Crude		Age-Adjusted ²	
	Number	Percent	Idaho ³	U.S. ⁴	Idaho ³	U.S. ⁴
ALL CAUSES	6,432	100.0%	766.1	820.7	633.3	624.2
1. Malignant neoplasms (cancer)	1,357	21.1%	161.6	172.9	133.3	135.9
2. Diseases of heart	1,322	20.6%	157.5	183.1	126.0	133.6
3. Chronic lower respiratory diseases	446	6.9%	53.1	50.6	43.2	38.6
4. Alzheimer's disease	432	6.7%	51.5	47.1	41.4	32.8
5. Cerebrovascular diseases	365	5.7%	43.5	50.3	35.1	36.9
6. Accidents (unintentional injury)	328	5.1%	39.1	32.9	36.0	28.7
7. Diabetes mellitus	169	2.6%	20.1	22.3	16.4	17.3
8. Influenza and pneumonia	124	1.9%	14.8	18.5	12.0	13.5
9. Nephritis, nephrotic syndrome & nephrosis	89	1.4%	10.6	15.0	8.7	11.3
10. Intentional self-harm (suicide)	83	1.3%	9.9	6.2	10.5	6.0
11. Chronic liver disease and cirrhosis	68	1.1%	8.1	9.0	7.3	7.6
12. Parkinson's disease	63	1.0%	7.5	6.8	6.4	5.1
13. Essential hypertension & hypertensive renal disease	60	0.9%	7.1	11.2	5.7	8.1
14. Septicemia	52	0.8%	6.2	13.1	5.1	10.1
15. Pneumonitis due to solids and liquids	46	0.7%	5.5	5.4	4.5	4.0
All other causes	1,428	22.2%	NA	NA	NA	NA

1. Rates are per 100,000 population. NA = not applicable. Rates are not applicable for all other causes.

2. Age-adjusted rates are artificial measures developed to eliminate the bias inherent in differing age compositions, thus allowing comparisons between geographic regions. Idaho and U.S. age-adjusted rates were calculated using the 2000 U.S. population estimate as the standard population.

3. Idaho rates are based on the July 1, 2016 population estimates.

4. Source U.S. crude and age-adjusted rates: Centers for Disease Control and Prevention, the National Center for Health Statistics. Rates are calculated using the 2010 Census provided by the U.S. Bureau of the Census.

Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2017.

IDAHO RESIDENT DEATHS

Ten Leading Causes of Death¹ by Age Group and Number of Deaths

2016

RANK	AGE GROUP												ALL AGES
	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+		
1	Congenital malformations 34	Accidents 10	Accidents 20	Accidents 73	Accidents 100	Accidents 99	Malignant neoplasms 159	Malignant neoplasms 523	Malignant neoplasms 786	Malignant neoplasms 851	Diseases of heart 1,223	Diseases of heart 2,974	
2	Short gestation/low birth weight 16	Congenital malformations 5	Malignant neoplasms 9	Intentional self-harm (suicide) 53	Intentional self-harm (suicide) 33	Intentional self-harm (suicide) 68	Diseases of heart 112	Diseases of heart 315	Diseases of heart 515	Diseases of heart 741	Malignant neoplasms 495	Malignant neoplasms 2,890	
3	(Tie) Maternal complications of pregnancy; Sudden infant death syndrome 13		Diseases of heart 4	(Tie) Assault (homicide); Malignant neoplasms 4	Malignant neoplasms 19	Diseases of heart 44	Accidents 98	Accidents 118	Chronic lower respiratory diseases 219	Chronic lower respiratory diseases 307	Alzheimer's disease 382	Chronic lower respiratory diseases 864	
4					Diseases of heart 12	Malignant neoplasms 42	Intentional self-harm (suicide) 79	Chronic lower respiratory diseases 111	Cerebrovascular diseases 97	Cerebrovascular diseases 204	Cerebrovascular diseases 298	Accidents 847	
5	Hydrops fetalis 6				Assault (homicide) 8	Chronic liver disease and cirrhosis 12	Chronic liver disease and cirrhosis 36	Diabetes mellitus 66	Diabetes mellitus 90	Alzheimer's disease 180	Chronic lower respiratory diseases 207	Cerebrovascular diseases 679	
6	(Tie) Accidents; Complications of placenta, cord, membranes 5				(Tie) Chronic liver disease (homicide); Diabetes mellitus 6	(Tie) Assault (homicide); Cerebrovascular diseases 8	Diabetes mellitus 27	Diabetes mellitus 63	72	101	153	606	
7							Chronic lower respiratory diseases 16	Cerebrovascular diseases 57	Chronic liver disease and cirrhosis 51	Accidents 99	Influenza and pneumonia 88	Diabetes mellitus 379	
8					Pregnancy, childbirth, and the puerperium 4	Diabetes mellitus 4	13	Intentional self-harm (suicide) 45	Intentional self-harm (suicide) 47	Parkinson's disease 75	Diabetes mellitus 82	Intentional self-harm (suicide) 351	
9							Influenza and pneumonia 10	Influenza and pneumonia 20	Nephritis 36	Nephritis 59	Parkinson's disease 67	Influenza and pneumonia 204	
10							Nephritis 9	Nephritis 19	Alzheimer's disease 34	Influenza and pneumonia 53	Nephritis 64	Chronic liver disease and cirrhosis 190	
Residual ²	45	10	16	21	45	71	133	349	498	763	1,100	3,386	
Total	137	25	49	155	233	356	692	1,686	2,445	3,433	4,159	13,370	

Nephritis is a shortened ICD-10 title for 'Nephritis, nephrotic syndrome, nephrosis'; Hydrops fetalis is short for 'Hydrops fetalis not due to hemolytic disease'; Congenital malformations is short for 'Congenital malformations, deformations, and chromosomal abnormalities.'

¹Data are shown for causes with 4 or more deaths for given age group. ²Total number of deaths for all other leading causes not listed and all other causes not ranked for leading cause of death.

Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2017.

IDAHO MALE RESIDENT DEATHS

Ten Leading Causes of Death¹ by Age Group and Number of Deaths

2016

RANK	AGE GROUP												ALL AGES
	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+		
1	Congenital malformations 15	Accidents 8	Accidents 8	Accidents 54	Accidents 73	Accidents 68	Diseases of heart 82	Malignant neoplasms 265	Malignant neoplasms 436	Malignant neoplasms 501	Diseases of heart 519	Diseases of heart 1,652	
2	(Tie) Short gestation/low birth weight; Sudden infant death syndrome 10		Malignant neoplasms 5	Intentional self-harm (suicide) 42	Intentional self-harm (suicide) 25	Intentional self-harm (suicide) 45	Malignant neoplasms 72	Diseases of heart 219	Diseases of heart 343	Diseases of heart 444	Malignant neoplasms 230	Malignant neoplasms 1,533	
3					Malignant neoplasms 9	Diseases of heart 33	(Tie) Accidents; Intentional self-harm (suicide) 61	Accidents 75	Chronic lower respiratory diseases 102	Chronic lower respiratory diseases 156	Chronic lower respiratory diseases 101	Accidents 519	
4	Maternal complications of pregnancy 7				(Tie) Assault (homicide); Diseases of heart 8	Malignant neoplasms 13	Chronic liver disease and cirrhosis 21	Chronic lower respiratory diseases 50	Cerebrovascular diseases 56	Cerebrovascular diseases 105	Alzheimer's disease 100	Chronic lower respiratory diseases 418	
5	Hydrops fetalis 4				Chronic liver disease and cirrhosis 4	(Tie) Assault (homicide); Chronic liver disease and cirrhosis 7	Chronic liver disease and cirrhosis 17	Cerebrovascular diseases 43	Diabetes mellitus 52	Diabetes mellitus 60	Cerebrovascular diseases 99	Cerebrovascular diseases 314	
6							Diabetes mellitus 39	Cerebrovascular diseases 39	Accidents 46	Alzheimer's disease 56	Accidents 70	Intentional self-harm (suicide) 268	
7						Cerebrovascular diseases 5	Cerebrovascular diseases 8	Diabetes mellitus 38	Intentional self-harm (suicide) 40	Accidents 54	Parkinson's disease 40	Diabetes mellitus 210	
8							Chronic lower respiratory diseases 7	Intentional self-harm (suicide) 32	Chronic liver disease and cirrhosis 38	Parkinson's disease 44	Diabetes mellitus 36	Alzheimer's disease 174	
9							(Tie) Nephritis; Septicemia 5	Nephritis 13	Nephritis 21	Nephritis 33	(Tie) Influenza and pneumonia; Nephritis	Chronic liver disease and cirrhosis 122	
10								Influenza and pneumonia 11	Parkinson's disease 18	Influenza and pneumonia 25	Parkinson's disease 26	Parkinson's disease 103	
Residual ²	29	8	11	17	28	39	75	191	281	373	417	1,625	
Total	75	16	24	113	155	217	414	976	1,433	1,851	1,664	6,938	

Nephritis is a shortened ICD-10 title for 'Nephritis, nephrotic syndrome, nephrosis'; Hydrops fetalis is short for 'Hydrops fetalis not due to hemolytic disease'; Congenital malformations is short for 'Congenital malformations, deformations, and chromosomal abnormalities.'

¹Data are shown for causes with 4 or more deaths for given age group.² Total number of deaths for all other leading causes not listed and all other causes not ranked for leading cause of death.

Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2017.

IDAHO FEMALE RESIDENT DEATHS

Ten Leading Causes of Death¹ by Age Group and Number of Deaths

2016

RANK	AGE GROUP												ALL AGES
	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+		
1	Congenital malformations 19		Accidents 12	Accidents 19	Accidents 27	Accidents 31	Malignant neoplasms 87	Malignant neoplasms 258	Malignant neoplasms 350	Malignant neoplasms 350	Diseases of heart 704	Malignant neoplasms 1,357	
2	(Tie) Short gestation/low birth weight; Maternal complications of pregnancy 6		(Tie) Diseases of heart; Malignant neoplasms 4	Intentional self-harm (suicide) 11	Malignant neoplasms 10	Malignant neoplasms 29	Accidents 37	Diseases of heart 96	Diseases of heart 172	Diseases of heart 297	Alzheimer's disease 282	Diseases of heart 1,322	
3					Intentional self-harm (suicide) 8	Intentional self-harm (suicide) 23	Diseases of heart 30	Chronic lower respiratory diseases 61	Chronic lower respiratory diseases 117	Chronic lower respiratory diseases 151	Malignant neoplasms 265	Chronic lower respiratory diseases 446	
4					(Tie) Diabetes mellitus; Diseases of heart; Pregnancy, childbirth, and the puerperium 4	Diseases of heart 11	Intentional self-harm (suicide) 18	Accidents 43	Cerebrovascular diseases 41	Alzheimer's disease 124	Cerebrovascular diseases 199	Alzheimer's disease 432	
5						Chronic liver disease and cirrhosis 5	Chronic liver disease and cirrhosis 15	Diabetes mellitus 28	Diabetes mellitus 38	Cerebrovascular diseases 99	Chronic lower respiratory diseases 106	Cerebrovascular diseases 365	
6							Diabetes mellitus 10	Chronic liver disease and cirrhosis 20	Accidents 26	Accidents 45	Accidents 83	Accidents 328	
7							Chronic lower respiratory diseases 9	Cerebrovascular diseases 18	Alzheimer's disease 19	Diabetes mellitus 41	Influenza and pneumonia 62	Diabetes mellitus 169	
8							Influenza and pneumonia 7	Intentional self-harm (suicide) 13	Influenza and pneumonia 16	Parkinson's disease 31	Diabetes mellitus 46	Influenza and pneumonia 124	
9							Cerebrovascular diseases 5	Septicemia 10	Nephritis 15	Influenza and pneumonia 28	Nephritis 38	Nephritis 89	
10							Nephritis 4	Influenza and pneumonia 9	Chronic liver disease and cirrhosis 13	Nephritis 26	Essential hypertension 35	Intentional self-harm (suicide) 83	
Residual ²	31	9	5	12	21	40	56	154	205	390	675	1,717	
Total	62	9	25	42	78	139	278	710	1,012	1,582	2,495	6,432	

Nephritis is a shortened ICD-10 title for 'Nephritis, nephrotic syndrome, nephrosis'; Congenital malformations is short for 'Congenital malformations, deformations, and chromosomal abnormalities'; Essential hypertension is short for 'Essential hypertension and hypertensive renal disease.'

¹Data are shown for causes with 4 or more deaths for given age group. ² Total number of deaths for all other leading causes not listed and all other causes not ranked for leading cause of death.

Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2017.

Years of Potential Life Lost Before Age 75
Ten Leading Causes of Death Based on Premature Mortality¹
Total Population and by Sex, 2016

Cause of Death (Ranked)	Persons Aged Less than 75 Years		Years of Potential Life Lost (YPLL) Before Age 75		
	Number of Deaths	Percent of Deaths	Average Number of YPLL per Death	Total Number of YPLL	YPLL Rate ²
Total	5,778	100.0%	17.2	99,343	6,280
1. Accidents (unintentional injury)	595	10.3%	31.6	18,826	1,190
2. Malignant neoplasms (cancer)	1,544	26.7%	11.9	18,430	1,165
3. Diseases of heart	1,010	17.5%	12.4	12,526	792
4. Intentional self-harm (suicide)	328	5.7%	30.1	9,886	625
5. Certain conditions originating in perinatal period	57	1.0%	74.5	4,247	268
6. Congenital malformations, deformations and chromosomal abnormalities	61	1.1%	58.6	3,576	226
7. Chronic lower respiratory diseases	350	6.1%	8.8	3,070	194
8. Chronic liver disease and cirrhosis	169	2.9%	16.6	2,812	178
9. Diabetes mellitus	196	3.4%	13.6	2,656	168
10. Cerebrovascular diseases	177	3.1%	11.0	1,950	123
All other causes	1,291	22.3%	N/A	N/A	N/A
Total Males	3,423	100.0%	17.6	60,161	7,534
1. Accidents (unintentional injury)	395	11.5%	32.3	12,762	1,598
2. Malignant neoplasms (cancer)	802	23.4%	11.1	8,932	1,119
3. Diseases of heart	689	20.1%	12.4	8,522	1,067
4. Intentional self-harm (suicide)	247	7.2%	30.0	7,404	927
5. Certain conditions originating in perinatal period	32	0.9%	74.5	2,384	299
6. Chronic liver disease and cirrhosis	113	3.3%	15.6	1,760	220
7. Congenital malformations, deformations and chromosomal abnormalities	30	0.9%	53.9	1,617	203
8. Diabetes mellitus	114	3.3%	13.6	1,549	194
9. Chronic lower respiratory diseases	161	4.7%	8.8	1,414	177
10. Cerebrovascular diseases	110	3.2%	11.5	1,261	158
All other causes	730	21.3%	N/A	N/A	N/A
Total Females	2,355	100.0%	16.6	39,183	5,002
1. Malignant neoplasms (cancer)	742	31.5%	12.8	9,498	1,212
2. Accidents (unintentional injury)	200	8.5%	30.3	6,064	774
3. Diseases of heart	321	13.6%	12.5	4,005	511
4. Intentional self-harm (suicide)	81	3.4%	30.6	2,483	317
5. Congenital malformations, deformations and chromosomal abnormalities	31	1.3%	63.2	1,959	250
6. Certain conditions originating in perinatal period	25	1.1%	74.5	1,863	238
7. Chronic lower respiratory diseases	189	8.0%	8.8	1,657	211
8. Diabetes mellitus	82	3.5%	13.5	1,107	141
9. Chronic liver disease and cirrhosis	56	2.4%	18.8	1,052	134
10. Cerebrovascular diseases	67	2.8%	10.3	689	88
All other causes	561	23.8%	N/A	N/A	N/A

1. Ranking based on total number of years of potential life lost (YPLL).

2. YPLL rate: Total number of years of potential life lost per 100,000 population aged less than 75 years.

N/A: not applicable. YPLL not applicable for "All other causes."

Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2017.

Idaho Leading Health Indicators



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Idaho Leading Health Indicators

Topic Area	Leading Health Indicator
Overweight/Obesity	Percentage of adolescents overweight/obese ¹ Percentage of Idaho adults who are overweight/obese ²
Tobacco Use	Percentage of adolescents who currently smoke ¹ Percentage of Idaho adults who are current smokers ² Percentage of Idaho adults who use smokeless tobacco ²
Immunization	Percentage of 19-35 month olds who received 4+doses of DTaP ³ Percentage of adolescents aged 13 to 15 years reporting having been vaccinated with 3+ doses of the HPV vaccine ³ Annual incidence of Pertussis (Whooping Cough) ⁴
Infectious Disease	Annual incidence rate of enteric diseases reportable to public health ⁴ Annual incidence of STDs (chlamydia, gonorrhea, syphilis - does <u>not</u> include HIV) ⁴
Perinatal Care	Percentage of Idaho mothers who received adequate prenatal care ⁵ Percentage of Idaho resident live births with low birth weight ⁵ Percentage of Idaho resident live births with pre-term delivery ⁵
Injury/Suicide	Percentage of adolescents who have attempted suicide ¹ Suicide death rates ⁶ Injury fatalities (ages 1-44) ⁶
Chronic Disease	Coronary heart disease prevalence ² Coronary heart disease death rates ⁶ Stroke prevalence ² Stroke death rates ⁶ Diabetes prevalence ²
Health Status/Behaviors	Percentage of Idaho adults who consume 5 or more servings of fruits and vegetables a day ² Percentage of Idaho adults aged 50-75 years of age who receive colorectal cancer screening based on the most recent guidelines ² Percentage of Idaho women aged 50-74 who receive a breast cancer screening based on the most recent guidelines ² Percentage of Idaho adults with no leisure time physical activity ² Percentage of Idaho adults who have not visited the dentist in the past 12 months ²
Access/Systems	Percentage of Idaho adults without healthcare coverage ² Percentage of Idaho adults without a usual healthcare provider ² Number of active primary care physicians per 100,000 ⁷
Reproductive Health	Adolescent pregnancy rates (ages 15-17) ⁵ Percentage of adolescents that had sexual intercourse for the first time at 15 years or younger ¹

Data Sources/Notes:

1. Idaho Youth Risk Behavior Survey (YRBS), Idaho State Department of Education (SDE).
2. Idaho Behavioral Risk Factor Surveillance System (BRFSS) Survey, Bureau of Vital Records and Health Statistics (BVRHS), Idaho Department of Health and Welfare (IDHW).
3. National Immunization Survey (NIS), National Center for Immunization and Respiratory Diseases (NCIRD), Centers for Disease Control and Prevention (CDC).
4. Idaho Reportable Diseases, Bureau of Communicable Disease Prevention (BCDP), IDHW.
5. Birth records, BVRHS, IDHW.
6. Mortality (Death) records, BVRHS, IDHW.
7. 2017 State Physician Workforce Data Book, Association of American Medical Colleges.

*In cases where leading health indicator point estimates do not differ in a statistically significant manner there may be programmatically significant differences which have been highlighted. Unless specified, differences in estimates should not be considered statistically significant.

**For indicator definitions see the associated Leading Health Indicator in the following pages (35-67).

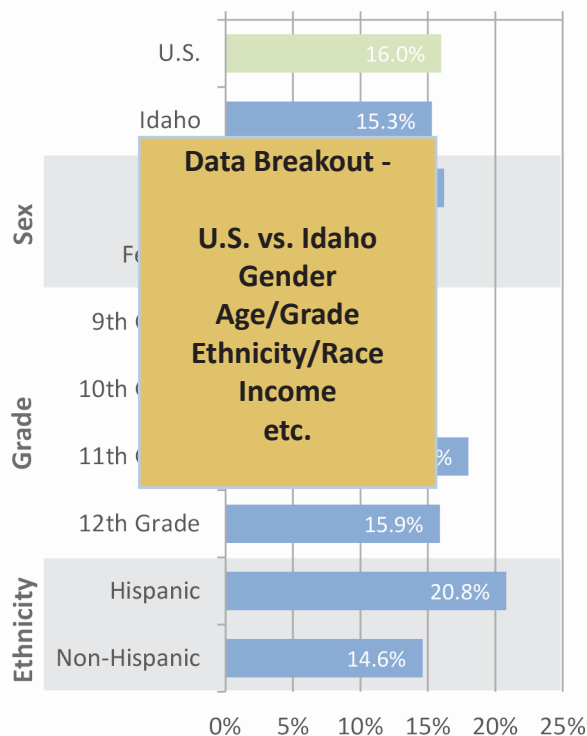
Understanding the Data Pages

Topic Area: Overweight/Obesity

Indicator: Percentage of adolescents (grades 9-12) who are overweight, 2015

10 Topic Areas
31 Indicators

The percentage of adolescents who are **overweight** in **Idaho** does not differ significantly from the **U.S.** Minor differences exist among some of the demographic groups listed below.¹



Overweight: students who were at or above the 85th percentile but below the 95th percentile for body mass index (BMI), based on sex- and age-specific reference data from the 2000 CDC growth charts.

Indicator defined

NOTE: In most cases, the ability to determine if differences between groups or years are statistically significant is not available. Where statistical significance is known it will be noted. In some cases "significance" is used to denote a difference that seem programmatically significant, but may not be statistically significant.

Data Source / Notes

How Many Adolescents?

13,000

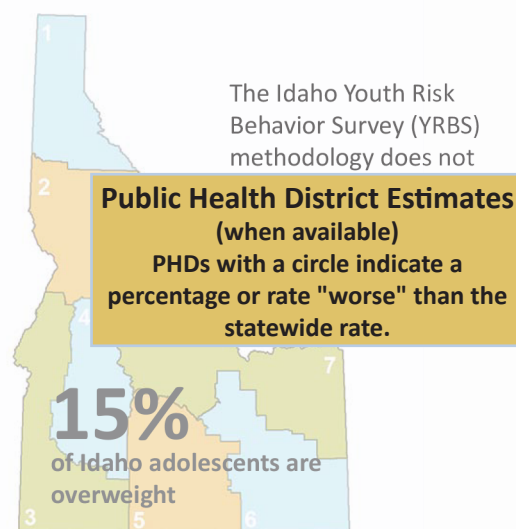
15% of adolescents are overweight

How many and who is at risk according to chart on the left

Who Are They?

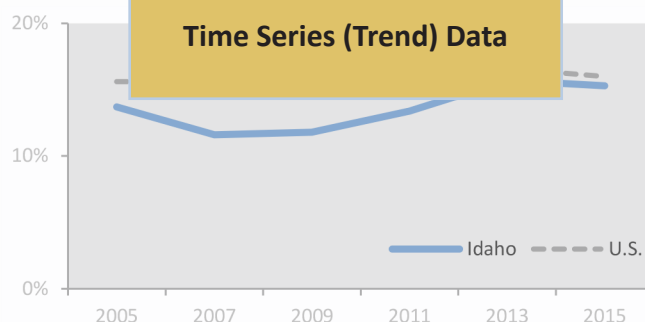
Hispanic students
21% vs. 15% of non-Hispanic students

Where Are They?



2005-2015

The percentage of adolescents in **Idaho** who are **overweight** has increased slightly since 2005. Idaho's overweight prevalence has been lower than the **U.S.** rate over the past 10 years, however since 2013 the rates have converged.

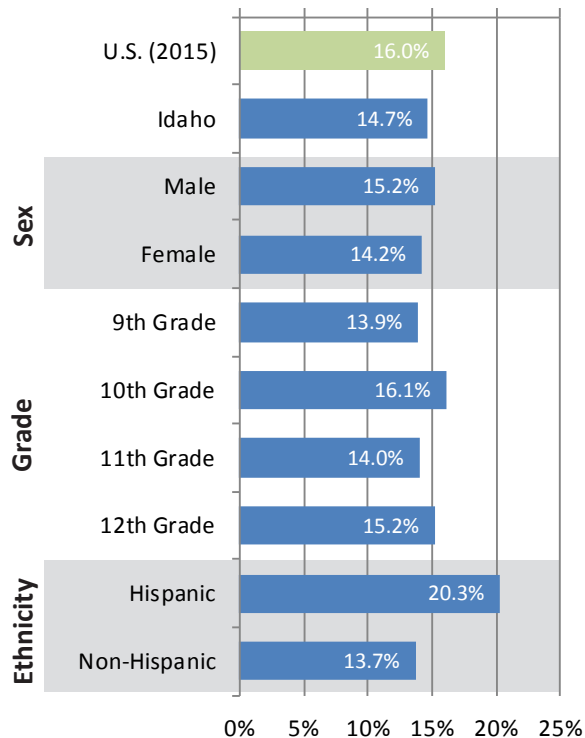


1. Centers for Disease Control and Prevention (CDC). 1991-2015 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed July, 2016.

Topic Area: Overweight/Obesity

Indicator: Percentage of overweight adolescents (grades 9-12), 2017

The percentage of adolescents who are **overweight** in **Idaho** does not differ significantly from the **U.S.** Minor differences exist among some of the demographic groups listed below.^{1,2}



Overweight: students who were at or above the 85th percentile but below the 95th percentile for body mass index (BMI), based on sex- and age-specific reference data from the 2000 CDC growth charts.

How Many Adolescents?

13,350

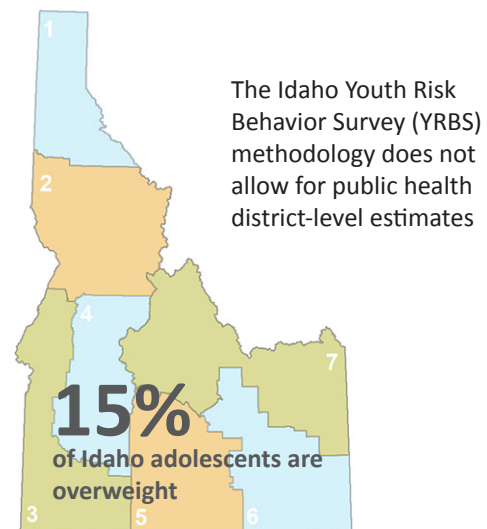
15% of Idaho adolescents (grades 9-12) are overweight

Who Are They?

Hispanic Students

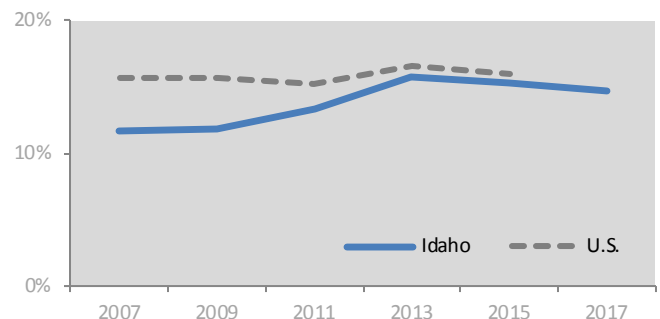
20% vs. 14% of non-Hispanic students

Where Are They?



2007-2017

The percentage of adolescents in **Idaho** who are **overweight** decreased slightly from 2013 to 2017, however since 2007 the rate has increased significantly. Idaho's overweight prevalence has been lower than the **U.S.** rate over the past 10 years, however since 2013 the rates have converged.^{1,2}



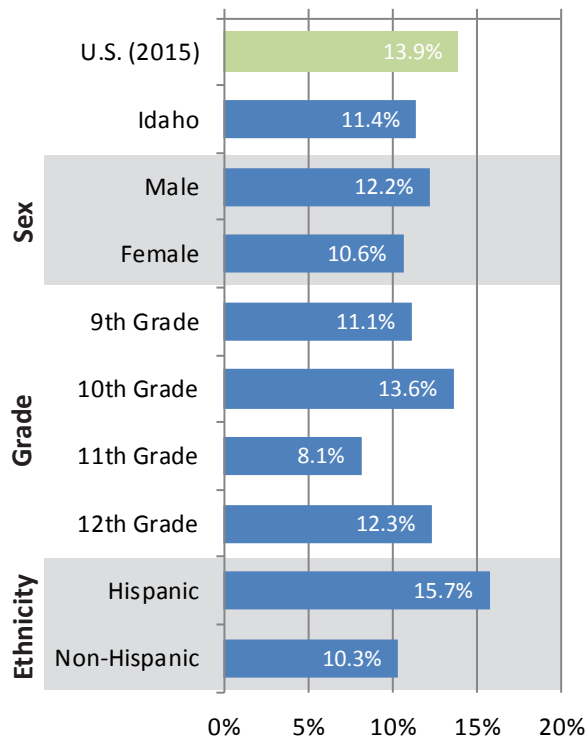
1. Idaho Source: *Idaho Youth Risk Behavior Survey: A Healthy Look at Idaho Youth*. Idaho State Department of Education, 2017.

2. Centers for Disease Control and Prevention (CDC). 1991-2015 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed December, 2017.

Topic Area: Overweight/Obesity

Indicator: Percentage of obese adolescents (grades 9-12), 2017

The percentage of adolescents who are obese in Idaho does not differ significantly from the **U.S.** rate.^{1,2} There are no statistically significant differences among sex, grade, or Hispanic ethnicity.



Obese: students who were at or above the 95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts.

How Many Adolescents?

9,800

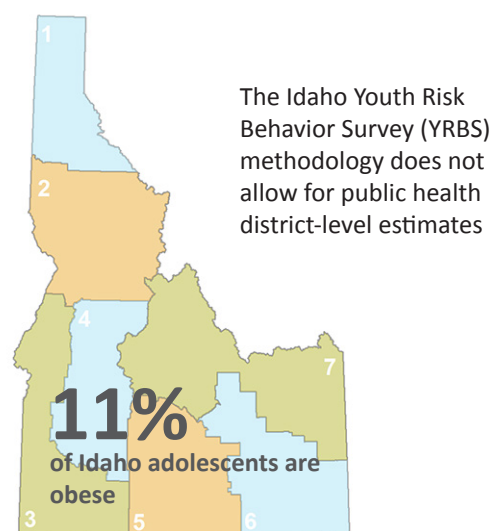
11% of Idaho adolescents (grades 9-12) are obese based on their BMI

Who Are They?

Hispanic Students

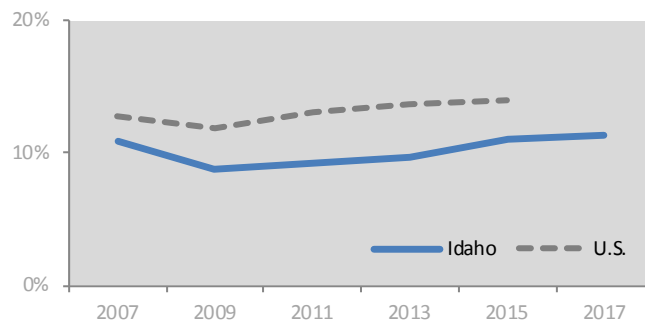
16% vs. 10% of non-Hispanic students are obese

Where Are They?



2007-2017

The percentage of obese adolescents in Idaho has increased significantly since 2011. Idaho's obesity prevalence has been consistently lower than the **U.S.** rate over the past 10 years.^{1,2}



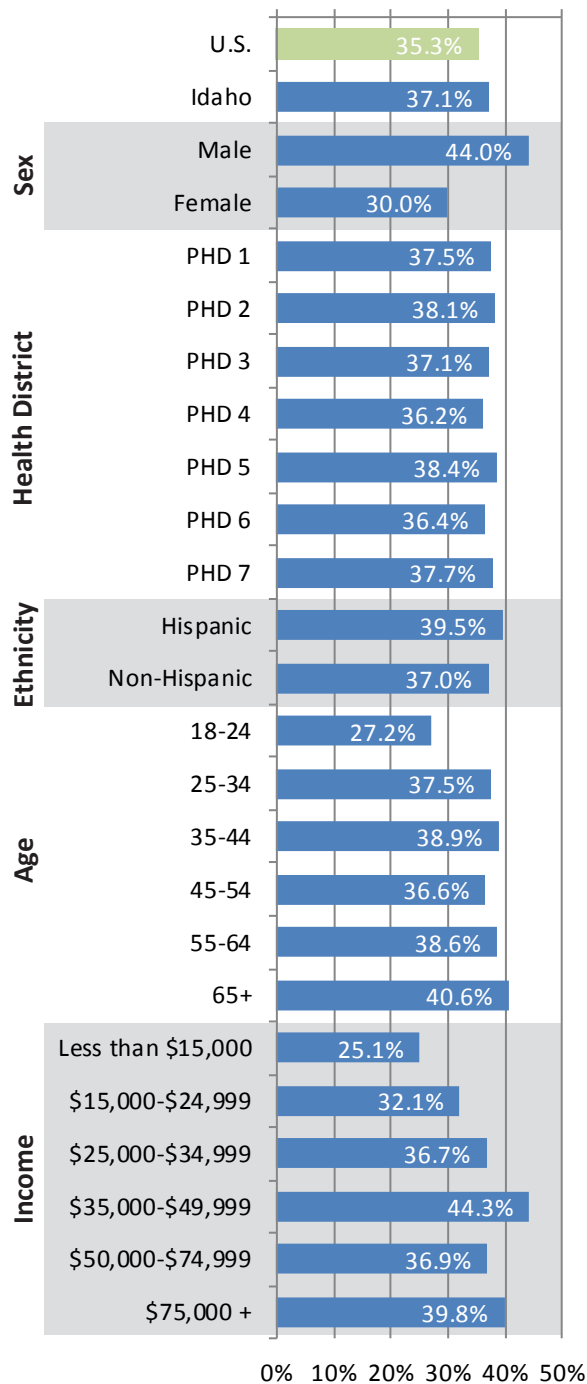
1. Idaho Source: *Idaho Youth Risk Behavior Survey: A Healthy Look at Idaho Youth*. Idaho State Department of Education, 2017.

2. Centers for Disease Control and Prevention (CDC). 1991-2015 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed December, 2017.

Topic Area: Overweight/Obesity

Indicator: Percentage of overweight (but not obese) adults, 2016

The percentage of overweight (but not obese) adults in Idaho is slightly higher than the U.S. median. Some significant differences exist among demographic groups.¹



Overweight is defined as a self-reported height and weight resulting in a calculated BMI greater than or equal to 25.0 but less than 30.0.

How Many Adults?

431,400

37% of Idaho adults are overweight

Who Are They?

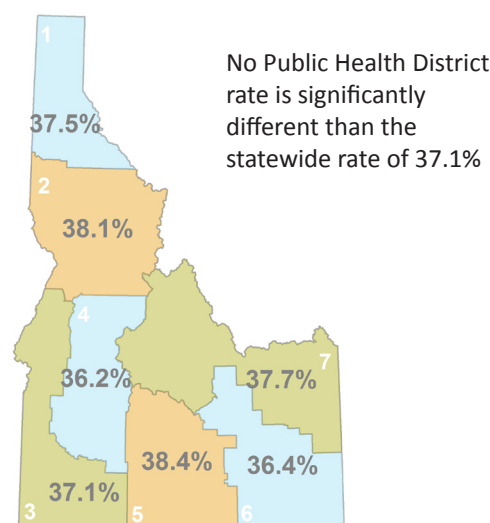
Males

44% vs. 30% of females are overweight

Income Above \$35,000

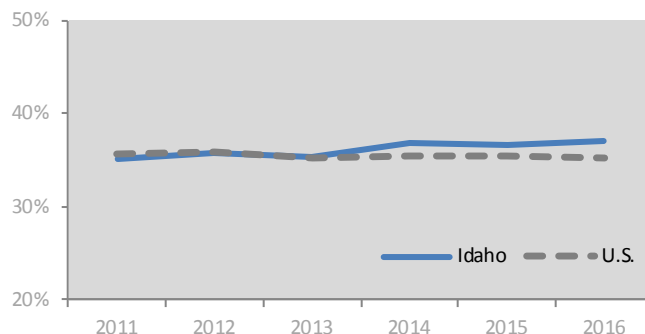
40% vs. 32% for incomes less than \$35,000

Where Are They?



2011-2016

The percentage of overweight (but not obese) adults in Idaho remained relatively unchanged from 2011 to 2016. Idaho's overweight (but not obese) is similar to the U.S. median.¹

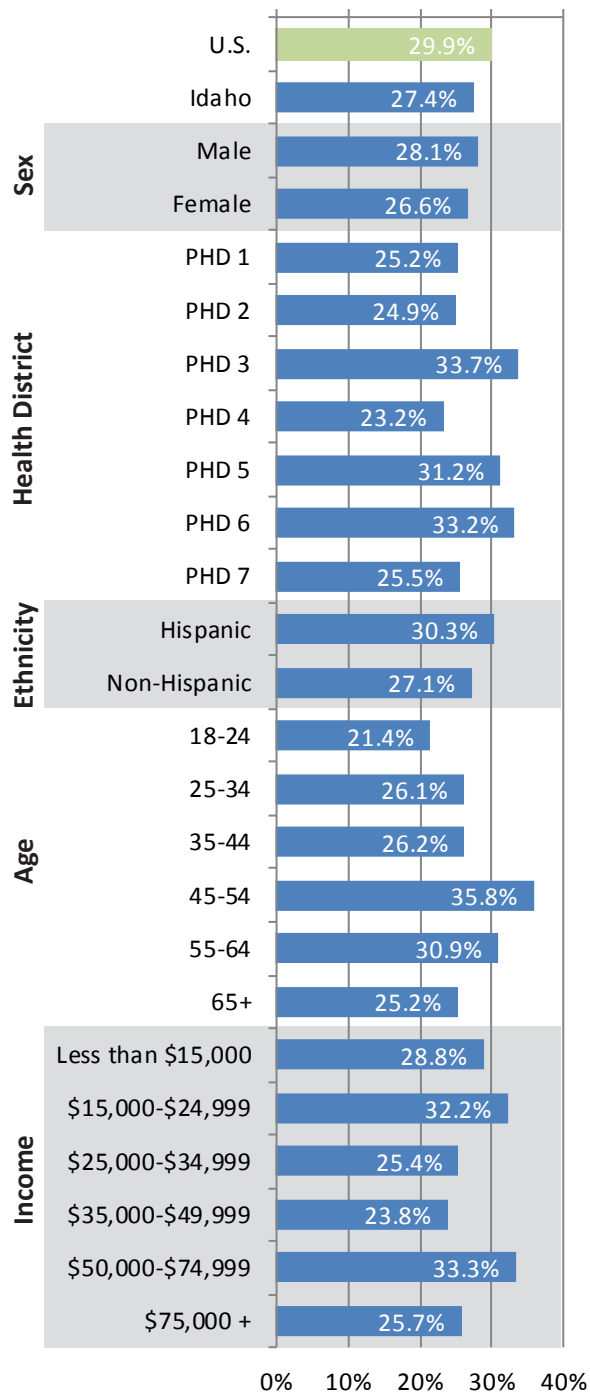


1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Overweight/Obesity

Indicator: Percentage of obese adults, 2016

The percentage of obese adults in Idaho is slightly lower than the U.S. median. Some significant differences exist among demographic groups.¹



Obese is defined as a self-reported height and weight resulting in a calculated BMI equal to or greater than 30.0.

How Many Adults?

318,300

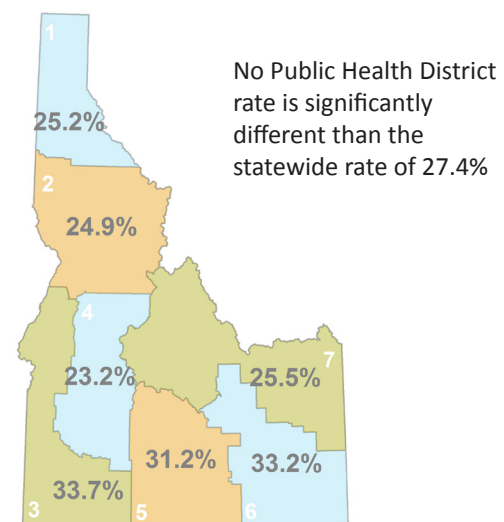
27% of Idaho adults are obese

Who Are They?

Middle-Aged Adults

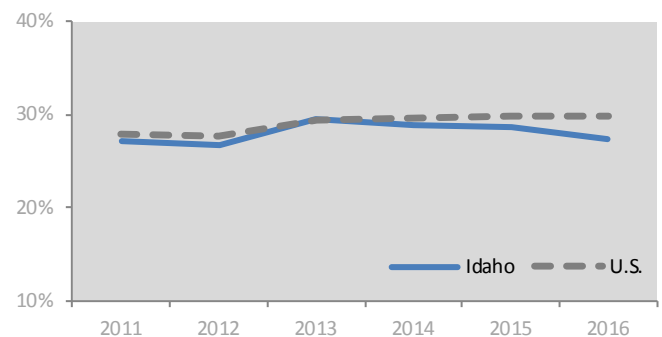
36% of adults aged 45-54 are obese

Where Are They?



2011-2016

The percentage of obese adults in Idaho remained relatively unchanged since 2011. Idaho's overweight prevalence is similar to the U.S. median.¹

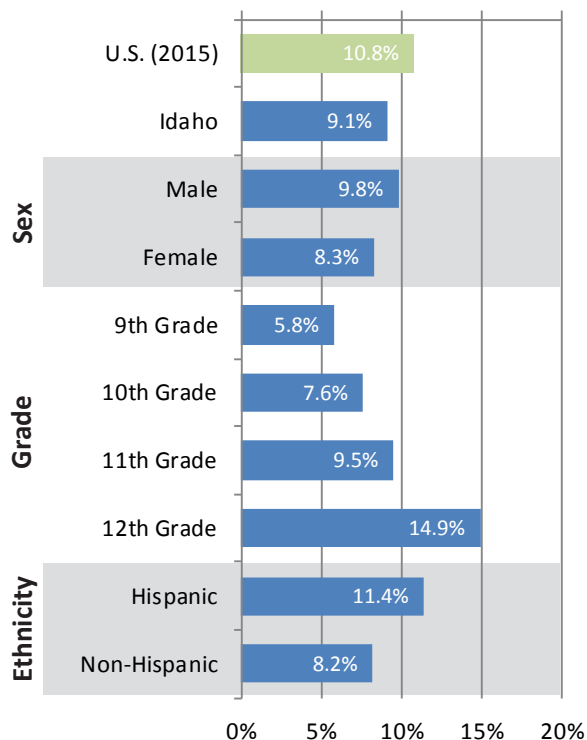


1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Tobacco Use

Indicator: Percentage of adolescent (grades 9-12) cigarette smokers, 2017

The percentage of adolescents in **Idaho** considered **current cigarette smokers** is lower than the **U.S.** rate. Some differences exist among demographic groups, but none of those differences (see chart below) are statistically significant.^{1,2}



Current smoking among adolescents is defined as self-reported cigarette smoking on 1 or more days of the 30 days prior to being surveyed.

How Many Adolescents?

8,000

9% of Idaho adolescents (grades 9-12) currently smoke cigarettes

Who Are They?

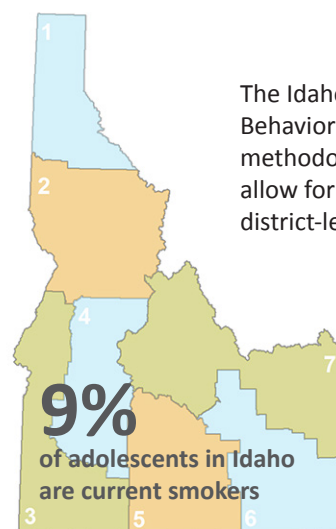
Older Students

Smoking increases slightly with grade-level

Hispanic Students

11% vs. 8% of non-Hispanic students are current smokers

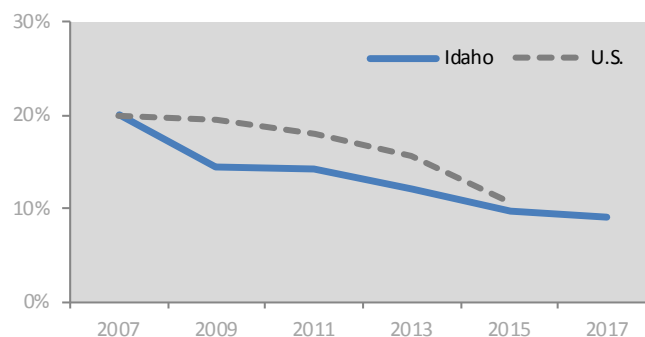
Where Are They?



The Idaho Youth Risk Behavior Survey (YRBS) methodology does not allow for public health district-level estimates

2007-2017

The percentage of adolescents in **Idaho** who are **current smokers** has decreased significantly since 2007. Idaho's cigarette smoking prevalence has been consistently lower than the **U.S.** rate over the past 10 years, however in 2015 they differed only slightly.^{1,2}



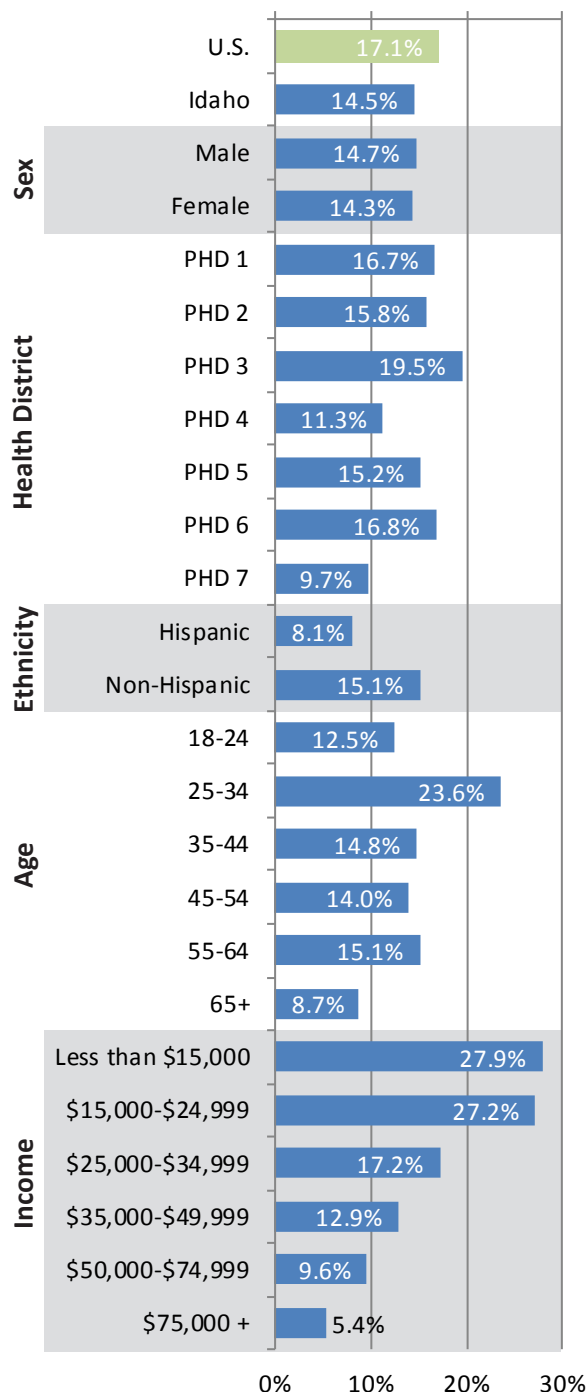
1. Idaho Source: *Idaho Youth Risk Behavior Survey: A Healthy Look at Idaho Youth*. Idaho State Department of Education, 2017.

2. Centers for Disease Control and Prevention (CDC). 1991-2015 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed December, 2017.

Topic Area: Tobacco Use

Indicator: Percentage of adults who smoke cigarettes, 2016

Cigarette smoking prevalence among **Idaho adults** is lower than the **U.S.** median. Some significant differences exist among demographic groups.¹



Current smoking is defined as having previously smoked 100 or more cigarettes and smoking on any of the 30 days prior to being surveyed.

How Many Adults?

173,900

15% of Idaho adults are cigarette smokers

Who Are They?

Lower Income Adults

Smoking tends to increase as income decreases

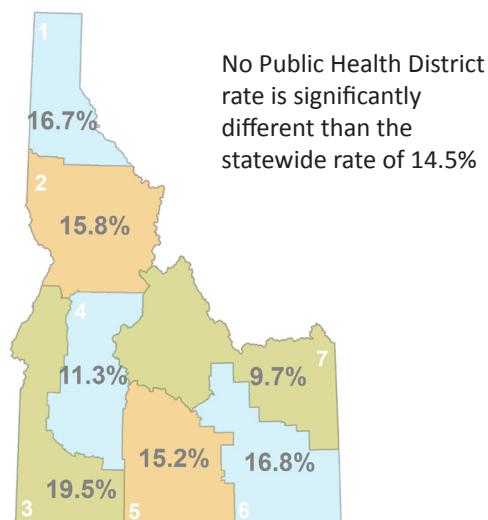
Young Adults (25-34 years)

24% of adults aged 25-34 smoke cigarettes

Non-Hispanic Adults

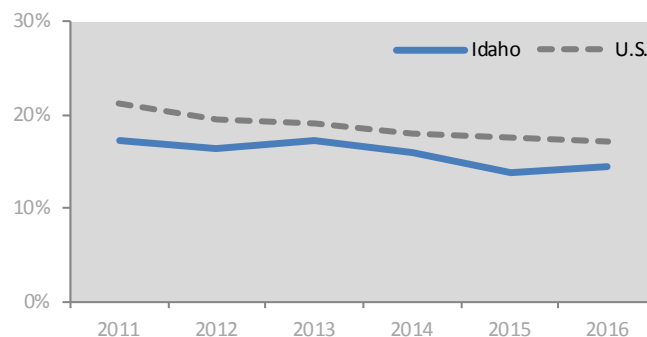
15% vs. 8% of Hispanic adults smoke cigarettes

Where Are They?



2011-2016

The percentage of adults in **Idaho** who smoke cigarettes decreased significantly since 2011. Idaho's smoking prevalence is lower than the **U.S.** median over the past 6 years.¹

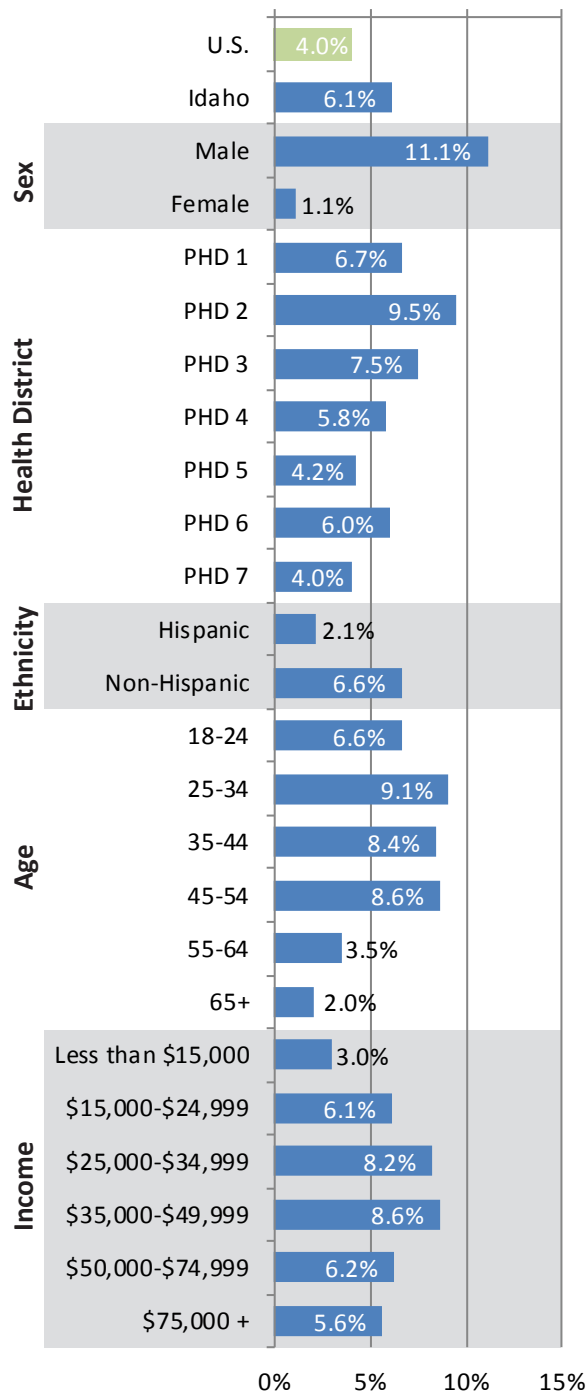


1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Tobacco Use

Indicator: Percentage of adults who use smokeless tobacco, 2016

The percentage of **Idaho adults** who are **smokeless tobacco users** is higher than the **U.S. median**. Some significant differences exist among the demographic groups listed below.¹



Current smokeless tobacco use is defined as an adult who selects the response option of "every day" or "some days" to the question, "Do you currently use chewing tobacco, snuff, or snus?"

How Many Adults?

72,500

6% of Idaho adults are smokeless tobacco users

Who Are They?

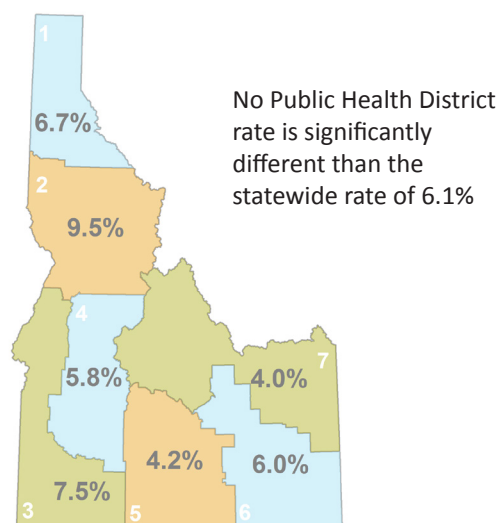
Males

11% vs. 1% of females are smokeless tobacco users

Non-Hispanic Adults

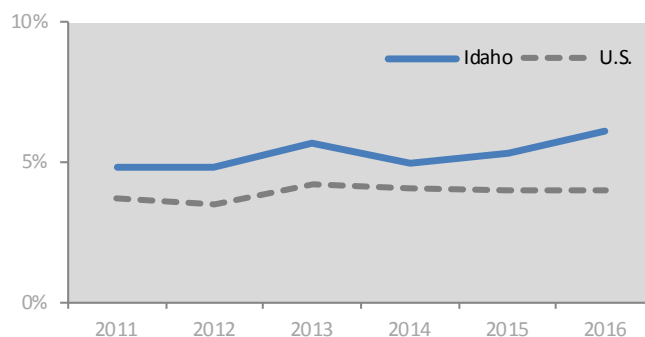
7% vs. 2% of Hispanics are smokeless tobacco users

Where Are They?



2011-2016

The percentage of adults in **Idaho** who use smokeless **tobacco** has remained relatively unchanged since 2011. Idaho's smokeless tobacco prevalence has been higher than the **U.S. median** since 2011.¹



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Immunization

Indicator: Percentage of 19-35 month-olds who received 4+ doses of DTaP, 2016

DTaP Immunization

The DTaP vaccine includes components that protect against diphtheria, tetanus, and pertussis.

The four-dose DTaP series is recommended to be administered at 2, 4, 6, and 15-18 months of age.

An additional booster dose of DTaP is recommended at 4-6 years of age (approximately at school-entry age).

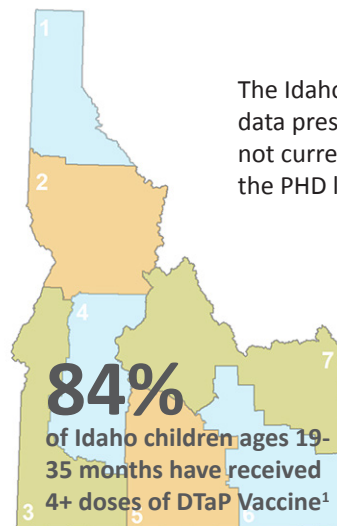
How Many Children Are Not Immunized?

16%

of Idaho children (ages 19-35 months) have not received 4+ doses of DTaP vaccine¹

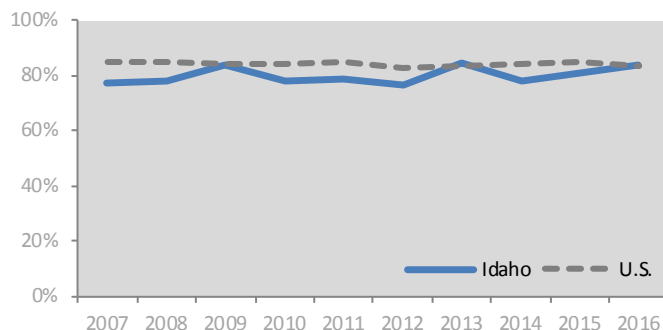
Note: a population estimate is not available for this measure.

Where Are They?



2007-2016

The percentage of children in Idaho (age 19-35 months) who received 4+ doses of the DTaP vaccine has remained relatively unchanged since 2007. Idaho's DTaP immunization rate has not been statistically different than the U.S. rate over the past 10 years.¹



1. Idaho Department of Health and Welfare, Division of Public Health, Idaho Immunization Program. Idaho and National Immunization Rates Child National Immunization Survey Data for US and Idaho, 2006-2015. Available at <http://www.healthandwelfare.idaho.gov/Portals/0/Health/Idaho%20Immunizations/Documents/2015%20Children%20NIS.pdf>. Accessed December, 2017.

Topic Area: Immunization

Indicator: Percentage of adolescents reported receiving 3+ doses of HPV vaccine (females aged 13-17 years), 2016

HPV Immunization

The Human Papillomavirus (HPV) vaccine routine administration schedule is to begin at 11 or 12 years, but as early as 9 years and be completed over the course of six months.

The quadrivalent HPV vaccine protects against two HPV strains that together account for 70% of cervical cancers. The other two components protect against HPV strains that cause other cancers and genital warts.

The 9-valent HPV (9vHPV) vaccine was approved by the FDA in December 2014. The additional five components included the 9vHPV vaccine increases the amount of strains protected against in about 90% of cervical cancers.

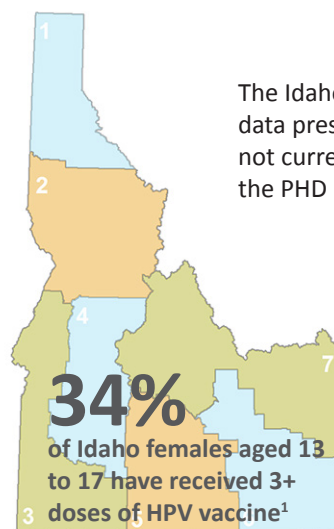
How Many Adolescent Females Are Not Vaccinated?

66%

of Idaho adolescent females (ages 13-17) have not received 3+ doses of HPV vaccination¹

Note: a population estimate is not available for this measure.

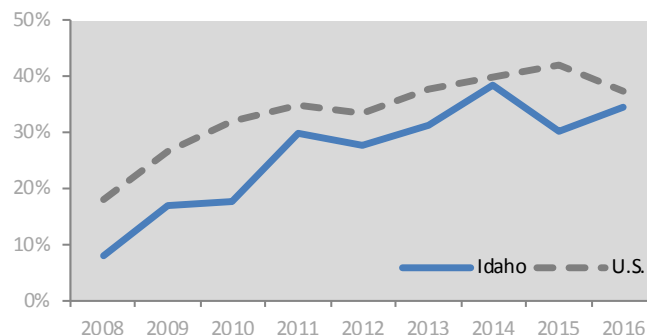
Where Are They?



The Idaho immunization data presented here are not currently available at the PHD level.

2008-2016

The percentage of females 13 to 17 years-of-age in Idaho who received 3+ doses of the HPV vaccine have been steadily rising since 2008 and have not differed significantly from the U.S. rate during that time.¹

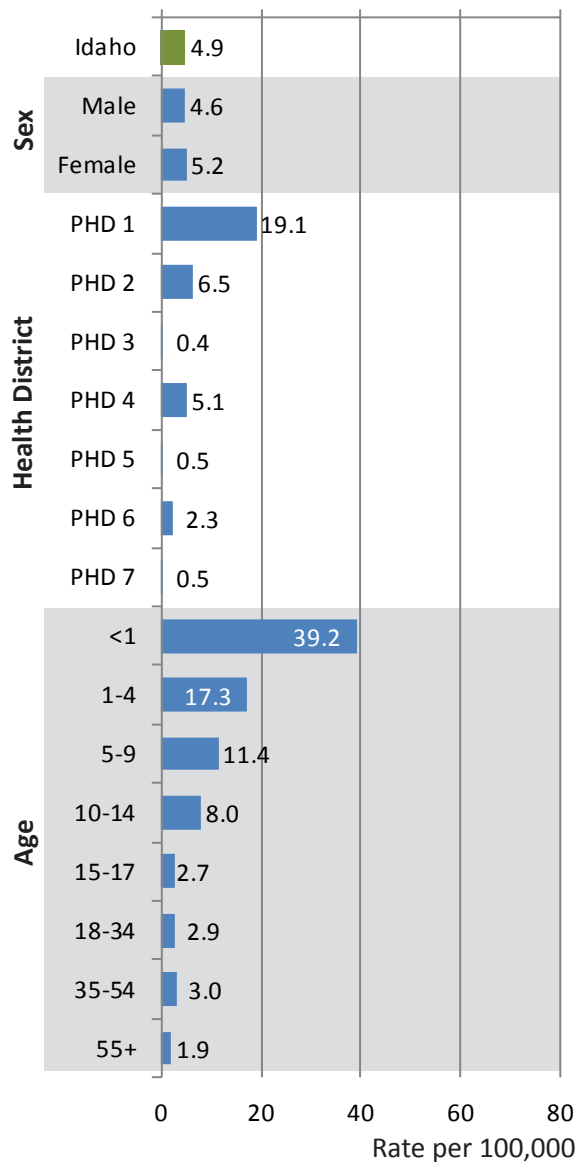


1. Idaho Department of Health and Welfare, Division of Public Health, Idaho Immunization Program. Idaho and National Immunization Rates Child National Immunization Survey Data for US and Idaho, 2006-2014. Available at <http://www.healthandwelfare.idaho.gov/Portals/0/Health/Immunizations/IIP/TEEN%20NIS.pdf?ver=2016-02-25-125350-950>. Accessed December, 2017.

Topic Area: Immunization

Indicator: Incidence rate of pertussis (whooping cough) reported to public health, 2016

The incidence rate of pertussis differs significantly among some of the groups listed below.

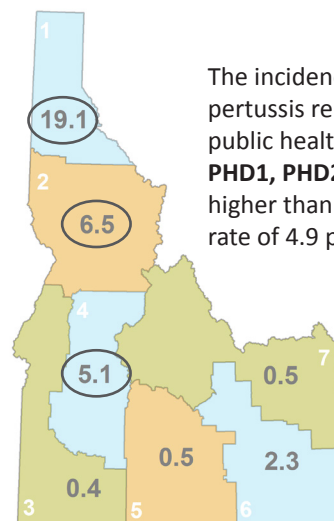


How Many Cases Reported?

83

cases of pertussis (whooping cough) were reported in 2016

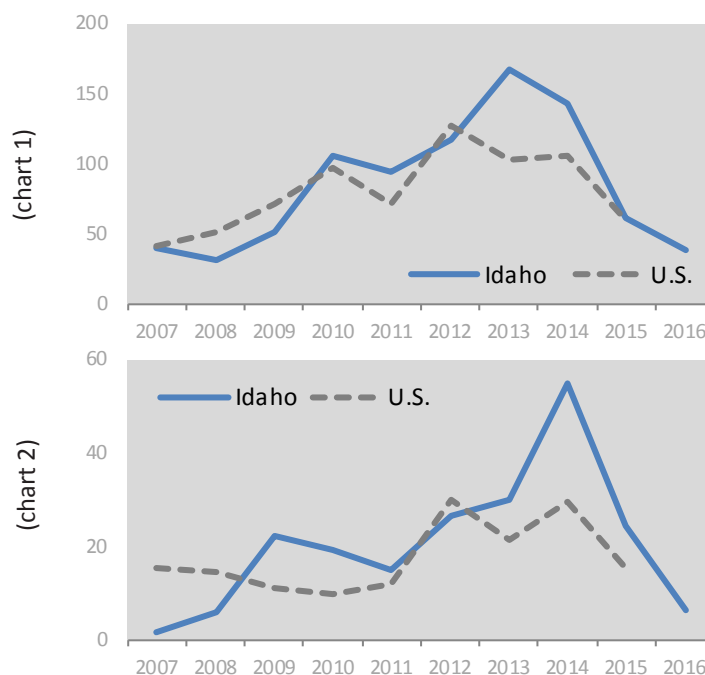
Where Are They?



The incidence rate of pertussis reported to public health in Idaho for **PHD1, PHD2, and PHD4** is higher than the statewide rate of 4.9 per 100,000.

2007-2016

The incidence rate of pertussis in **Idaho** among **infants <1 year of age** (chart 1) and **kids 11-18 years of age** (chart 2) varies from year to year and peaks every 3 to 5 years. Idaho's pertussis incidence rate trend has been similar to the **U.S.** rates over the past 10 years.



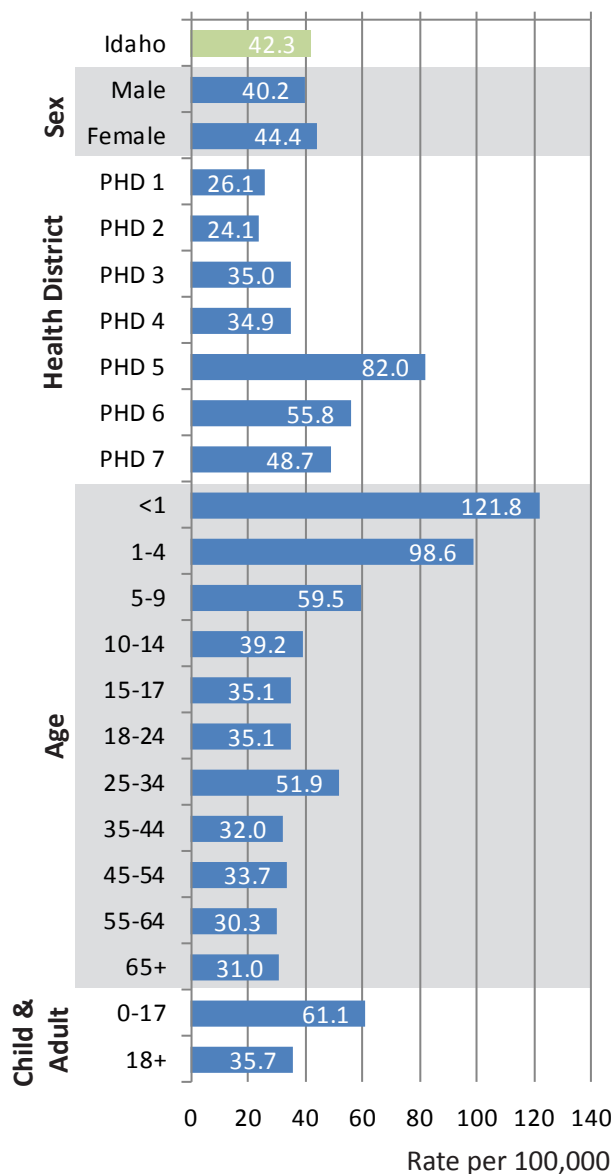
1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Communicable Disease Prevention, Epidemiology Program. Pertussis Incidence Rates 2007-2016. Special request November, 2017.

Topic Area: Infectious Disease

Indicator: Incidence rate of enteric diseases reported to public health, 2016

The incidence rate (per 100,000) of specified enteric diseases reported to public health in

Idaho includes reported cases of cryptosporidiosis, giardiasis, listeriosis, salmonellosis, shiga toxin-producing *Escherichia coli* (STEC), and shigellosis.¹



How Many Cases Reported?

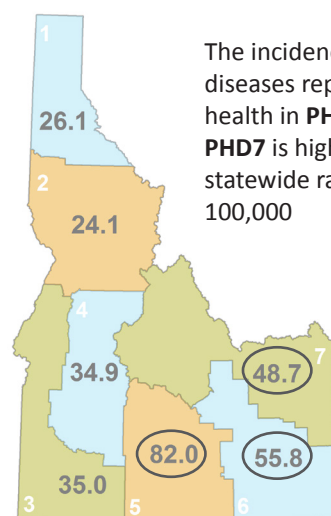
712

cases of enteric diseases were reported to public health in Idaho during 2016 (42.3 per 100,000 persons)

Enteric Outbreaks

Outbreaks of enteric diseases occur every year. In 2016, approximately one-third (37.2%) of all cases of enteric illness reported to public health officials in Idaho were associated with an outbreak.

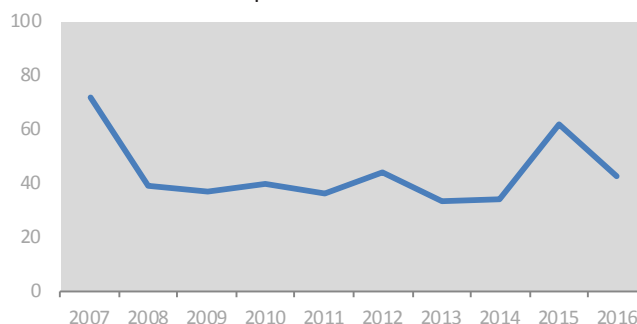
Where Are They?



The incidence rate of enteric diseases reported to public health in **PHD5, PHD6, and PHD7** is higher than the statewide rate of 42.3 per 100,000

2007-2016

The incidence rate of enteric diseases reported to public health in **Idaho** peaked in 2007 and 2016.¹



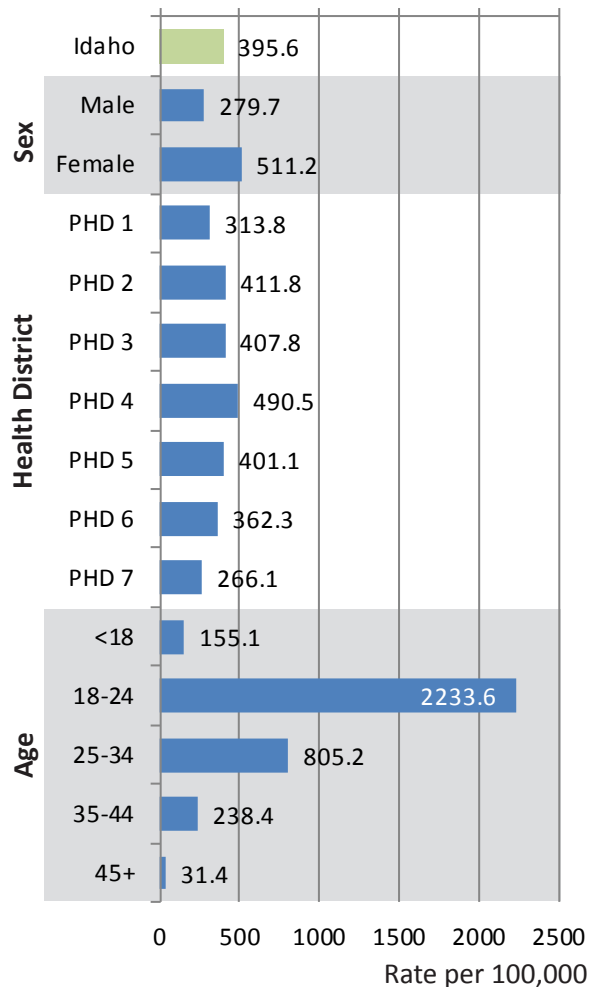
1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Communicable Disease Prevention, Epidemiology Program. Enteric diseases Incidence Rates 2007-2016. Special request November, 2017.

Topic Area: Infectious Disease

Indicator: Incidence of sexually transmitted diseases (STDs) reported to public health, 2016

The incidence rate (per 100,000) of STDs

reported to public health in Idaho includes reported cases of chlamydia, gonorrhea, or syphilis. Females and young adults in Idaho have the highest risk for contracting one of these STDs.¹



How Many Cases?

6,659

Cases of chlamydia, gonorrhea, or syphilis were reported in 2016

Who Are They?

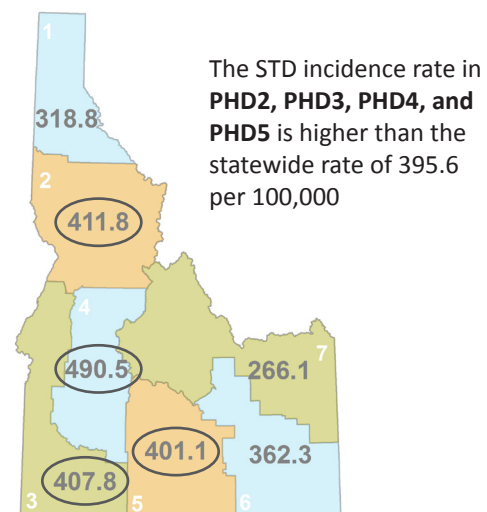
Females

Females are nearly twice as likely as men to be diagnosed with chlamydia, gonorrhea, or syphilis

Young Adults (18-24 years)

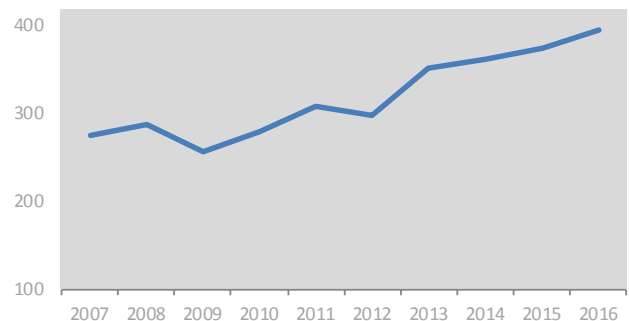
Idahoans aged 18 to 24 are significantly more likely to be diagnosed with and STD than older adults

Where Are They?



2007-2016

The incidence rate of STDs has increased significantly since 2007. The increase in the overall rate can be attributed to increases in all three STDs (chlamydia, gonorrhea, and syphilis). The equivalent U.S. rate is not available, but U.S. rates of all 3 STDs have increased significantly during the same time-period.¹

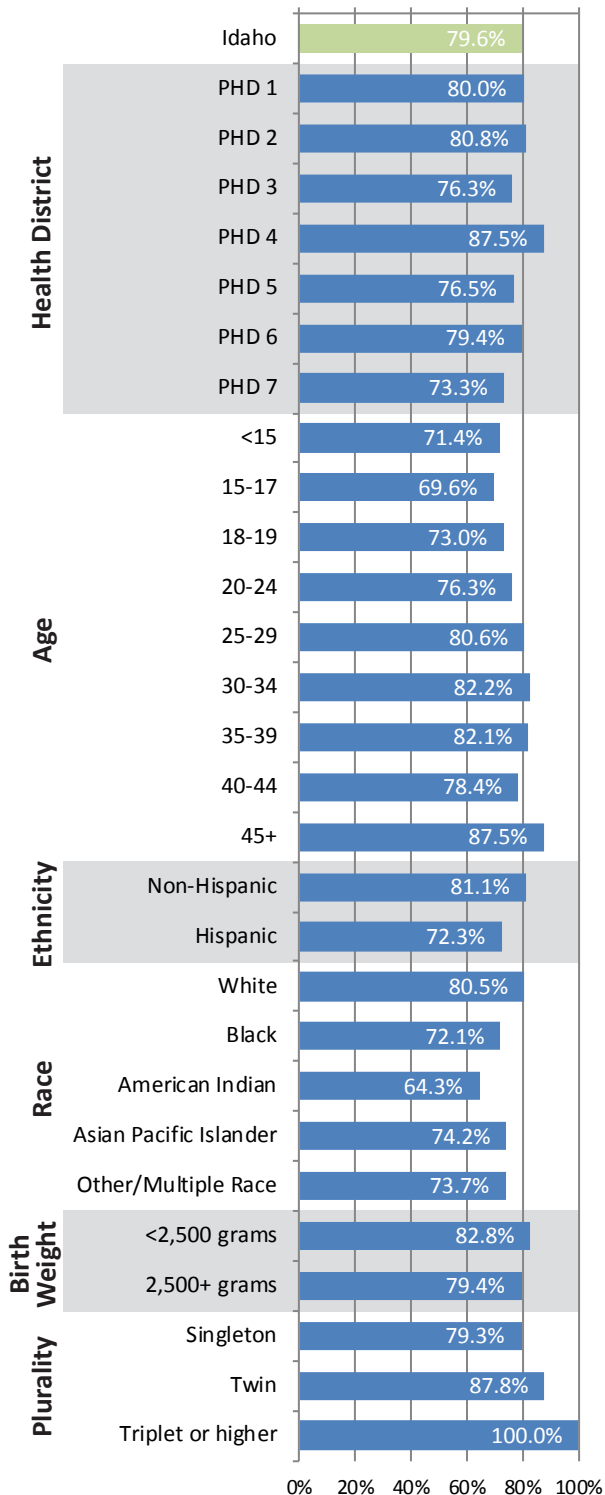


1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Communicable Disease Prevention, Epidemiology Program. Sexually Transmitted Disease Incidence Rates 2005-2016. Special request - November, 2017.

Topic Area: Perinatal Care

Indicator: Percentage of mothers who received adequate (or more) prenatal care, 2016

The percentage of mothers who received adequate (or more) prenatal care in Idaho differs among some of the demographic groups listed below.¹



Adequate prenatal care is defined as initiating prenatal care in the first trimester with nine or more visits.

How Many Mothers?

17,659

Idaho mothers received adequate prenatal care vs. 4,519 who did not receive adequate prenatal care in 2016

Who Are They?

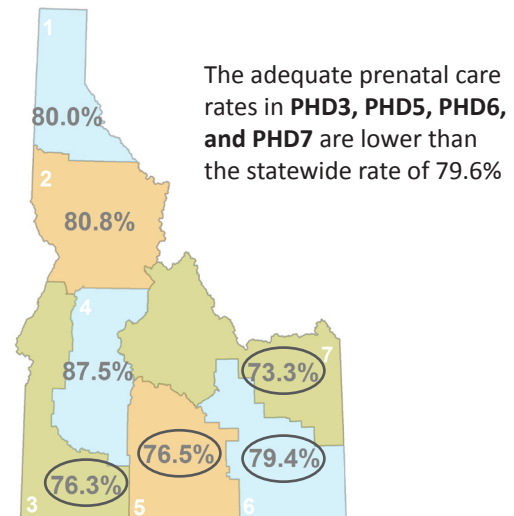
Young Mothers

Younger mothers (<15 to 18 years) are much less likely to receive adequate prenatal care

American Indian Mothers

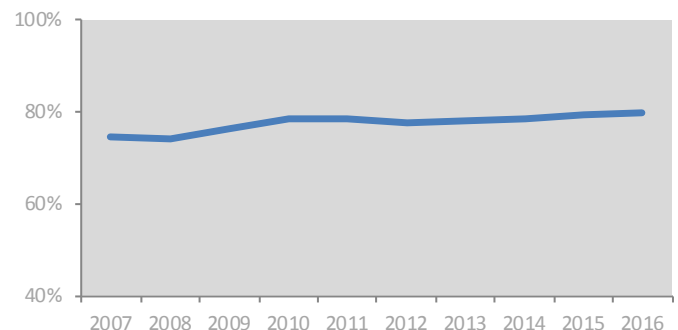
64% vs. 80% of White mothers received adequate prenatal care

Where Are They?



2007-2016

The percentage of mothers in Idaho who received adequate (or more) prenatal care has remained relatively unchanged since 2007.¹

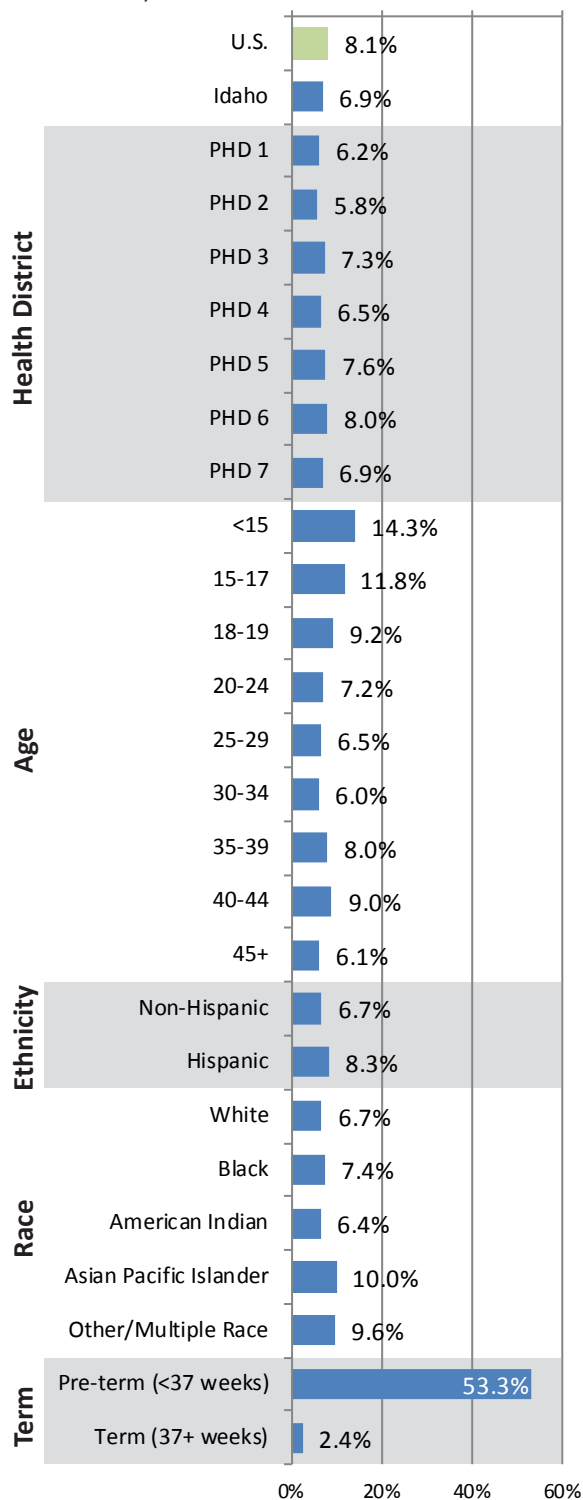


1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2017.

Topic Area: Perinatal Care

Indicator: Percentage of Idaho resident live births with a low birthweight, 2016

Low birthweight births in Idaho do not differ significantly from the U.S. rate. There are some differences seen among age of mother and term (pre-term vs. term).¹



Low birthweight is defined as a birth weight of less than 2,500 grams.

How Many Low Birthweight Births?

1,559

Births were considered to be a low birthweight births (<2,500 grams) in 2016

Who Are They?

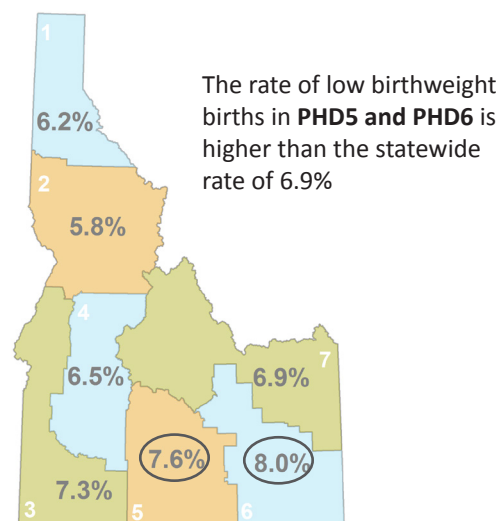
Younger and Older Mothers

Younger mothers (<15 to 18 years) and older mothers (45+ years) are more likely to have a low birthweight delivery

Pre-term births

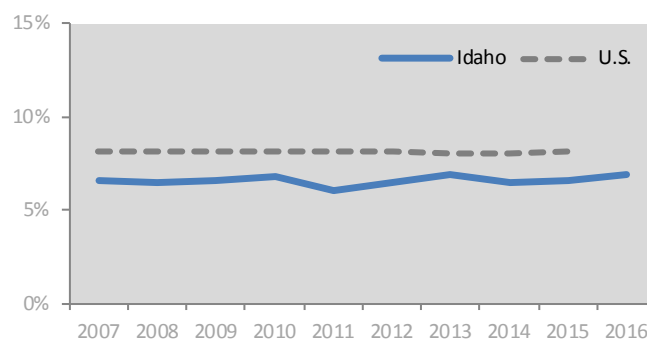
53% vs. 2% of full term births result in a low birthweight birth

Where Are They?



2007-2016

The percentage of low birthweight births in Idaho has remained relatively unchanged since 2007. Idaho's low birthweight rate has consistently been lower than the U.S.

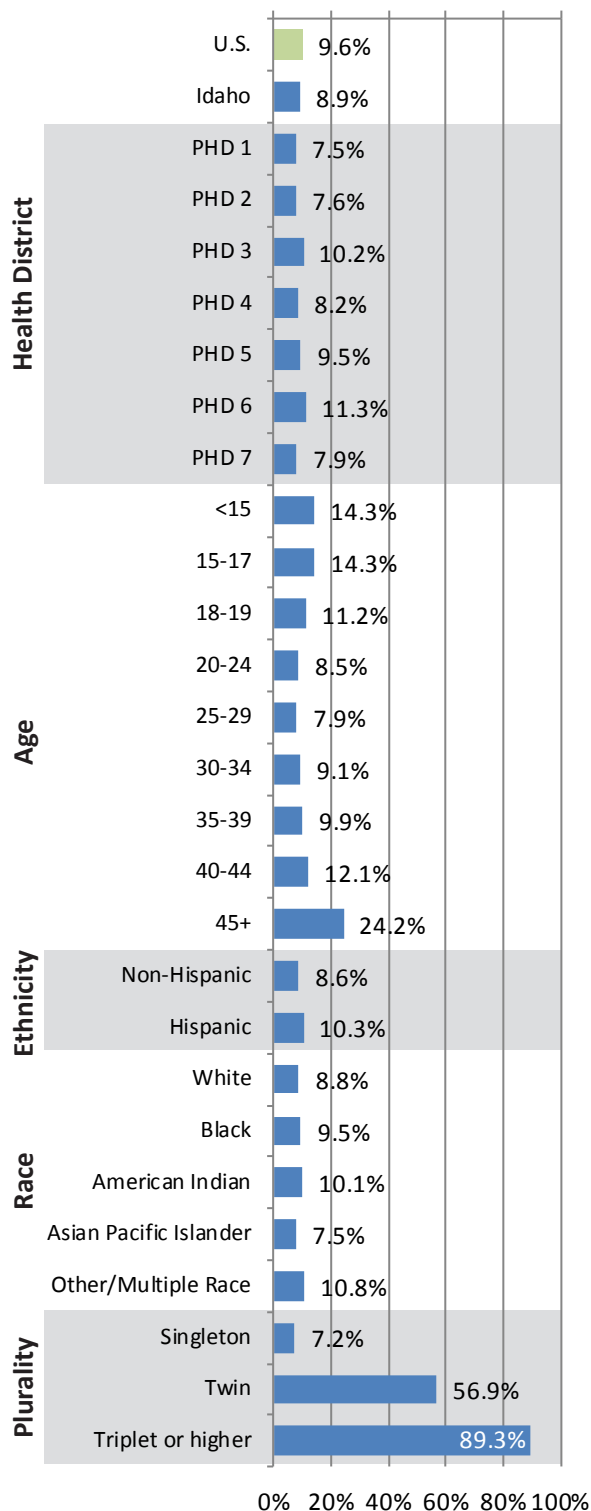


1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2017.

Topic Area: Perinatal Care

Indicator: Percentage of Idaho resident live births with a pre-term delivery (<37 weeks), 2016

The percentage of live births with a pre-term delivery among Idaho mothers differs significantly by age and plurality.¹



How Many Pre-term Births?

1,991

Pre-term deliveries (i.e., <37 weeks) in 2016

Who Are They?

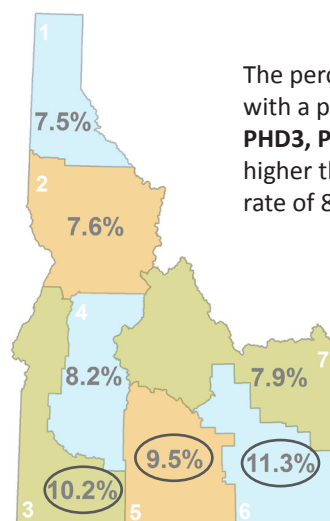
Younger and Older Mothers

Younger (<15 to 18 years) and older (45+) mother's pregnancies are more likely to result in a pre-term birth

Twins, Triplets or Higher

57% (twins), 89% (triplets or higher) vs. 7% of singleton births

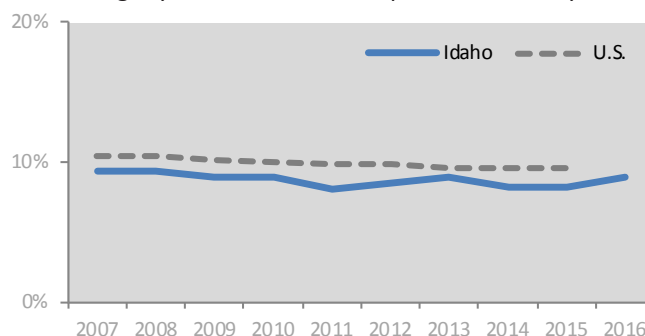
Where Are They?



The percentage of live births with a pre-term delivery in **PHD3, PHD5, and PHD6** is higher than the statewide rate of 8.9%

2007-2016

The percentage of Idaho resident births with a pre-term delivery has decreased slightly since 2007, and remains slightly lower than the U.S. pre-term delivery rate.¹

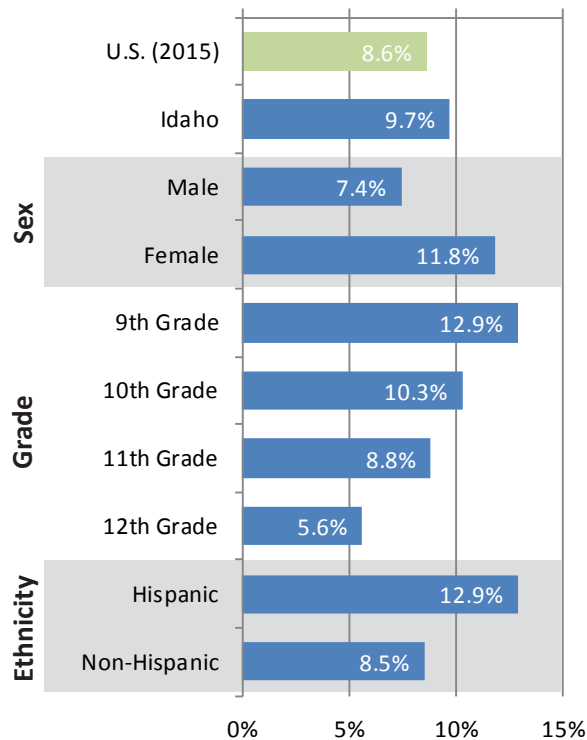


1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2017.

Topic Area: Injury/Suicide

Indicator: Percentage of adolescents who have attempted suicide in the past 12 months, 2017

The percentage of **Idaho adolescents** who have **attempted suicide** does not differ significantly from the **U.S.** rate. The attempted suicide rate is significantly higher among female students (vs. male students).¹



How Many Adolescents?

8,900

10% of Idaho adolescents (grades 9-12) have attempted suicide one or more times during the previous 12 months

Who Are They?

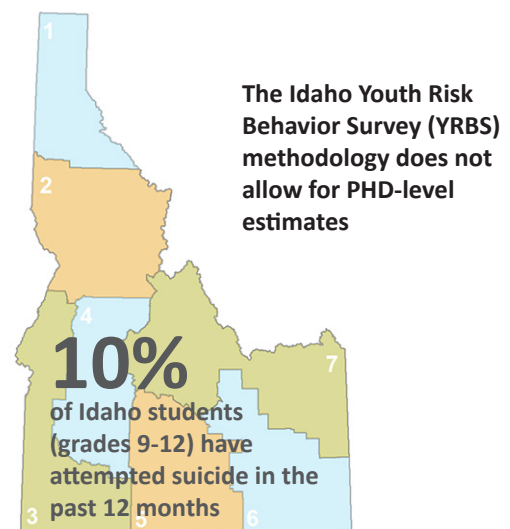
Female Students

12% vs. 7% of male students have attempted suicide

Hispanic Students

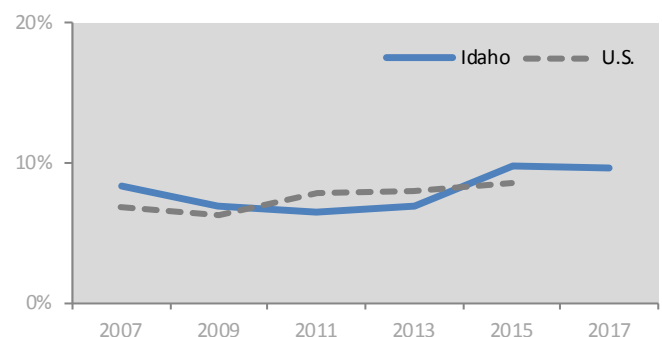
13% vs. 9% on non-Hispanic students have attempted suicide

Where Are They?



2007-2017

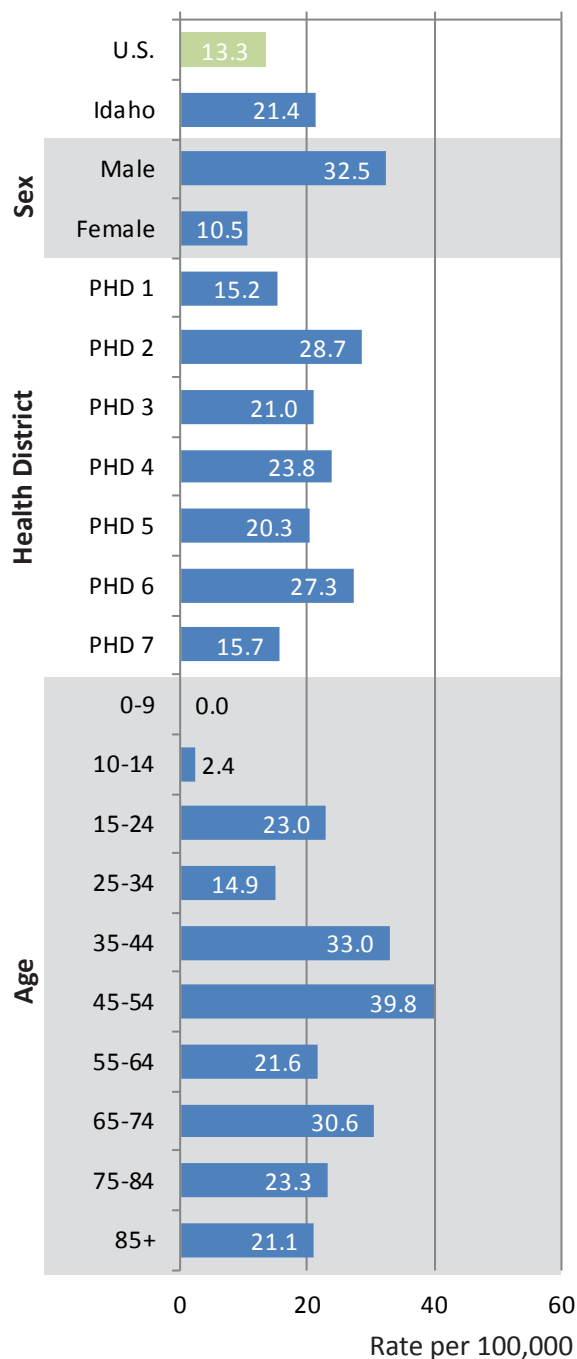
The percentage of adolescents in **Idaho** who have **attempted suicide during the past 12 months** has not changed significantly since 2007. Idaho's prevalence of suicide attempts has not differed significantly from the **U.S.** rate over the past 10 years.¹



Idaho Source: *Idaho Youth Risk Behavior Survey: A Healthy Look at Idaho Youth*. Idaho State Department of Education, 2017.

1. Centers for Disease Control and Prevention (CDC). 1991-2015 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed December, 2017.

The suicide death rate (age-adjusted) in **Idaho** is higher than the age-adjusted **U.S.** suicide death rate. Some highly significant differences exist between males and females and some age groups.¹



How Many Suicide Deaths?

351

21 suicide deaths per 100,000 Idahoans

Who Are They?

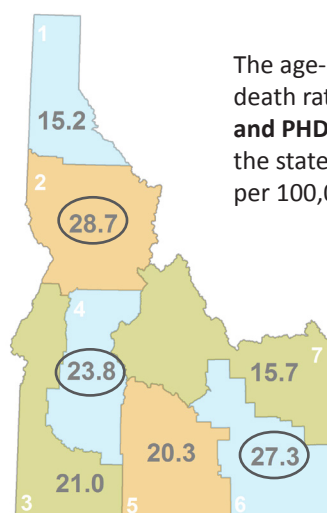
Males

33 per 100,000 vs. 11 per 100,000 females died by suicide

Middle Aged Adults (45-54 years)

The age-specific suicide death rate is highest among adults aged 45 to 54 years

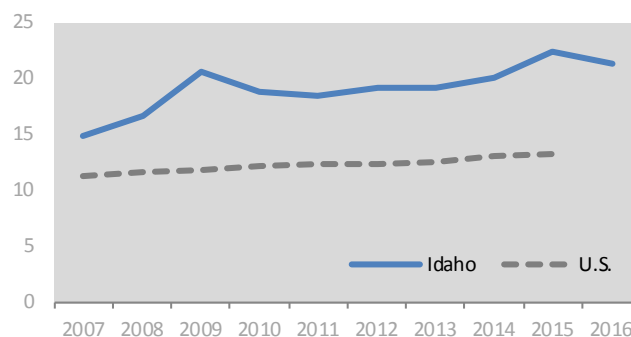
Where Are They?



The age-adjusted suicide death rate in **PHD2, PHD4, and PHD6** is higher than the statewide rate of 21.4 per 100,000 population.

2007-2016

The age-adjusted suicide rate (per 100,000) among **Idaho** residents is significantly higher than the **U.S.** suicide rate over the past 10 years. The suicide death rate in **Idaho** has increased since 2007.¹

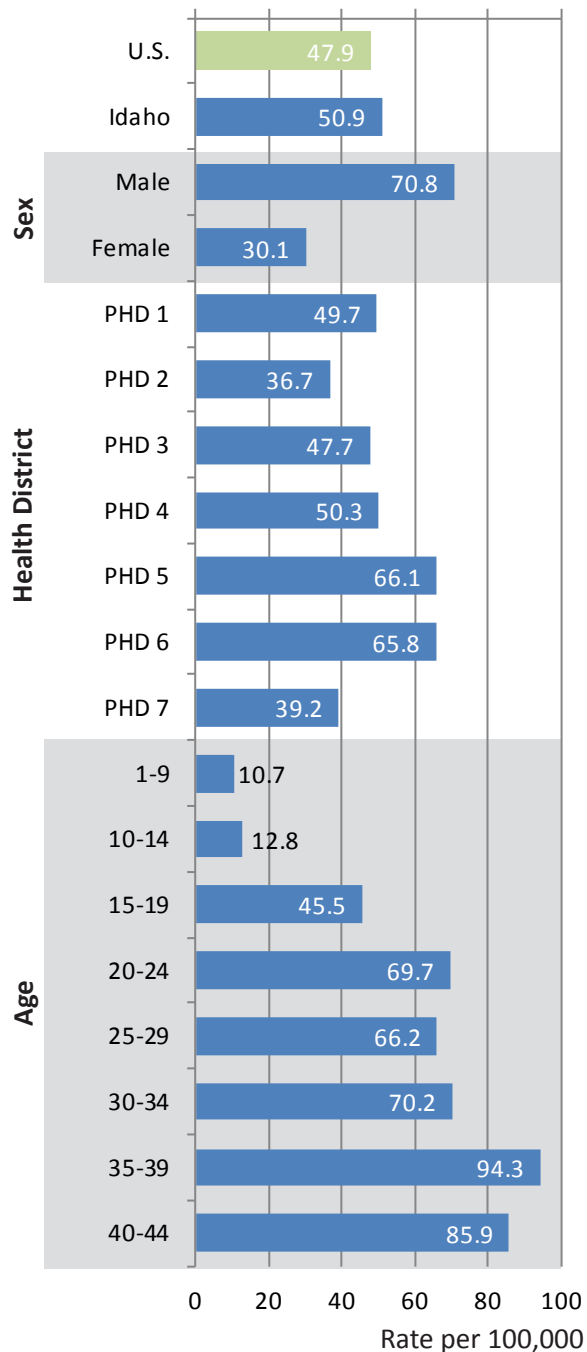


1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2017.

Topic Area: Injury/Suicide

Indicator: Injury fatalities (ages 1-44), 2016

Injury death rate (age-adjusted) among Idahoans aged 1-44 is slightly higher than the **U.S.** injury death rate. Some significant differences exist between males and females and some age groups.¹



How Many Injury Deaths?

508

51 injury deaths per 100,000 Idahoans aged 1-44 years

Who Are They?

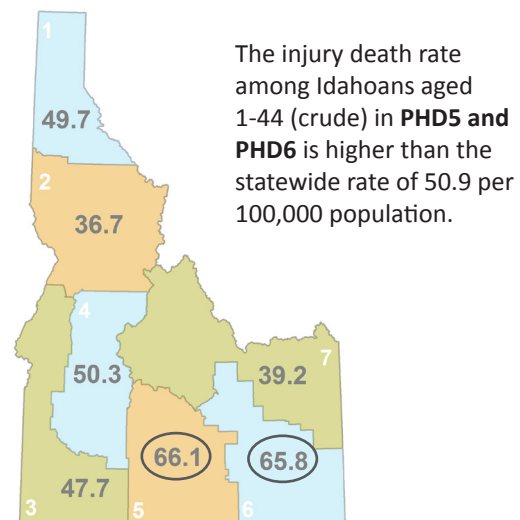
Males

71 per 100,000 males vs. 30 per 100,000 females died from an injury

Adults (25-39 years)

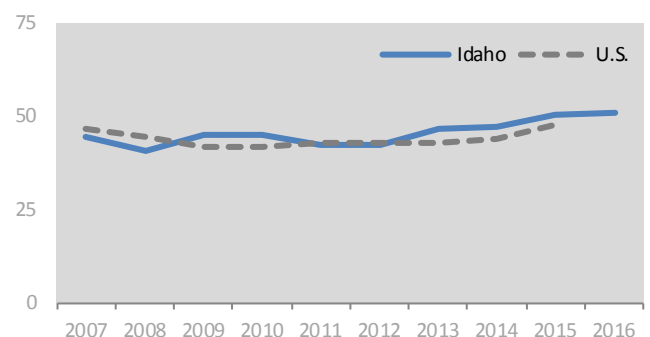
The injury death rate increases with age but is highest among adults 25 to 39 years

Where Are They?



2007-2016

The injury death rate (per 100,000) among Idaho residents aged 1-44 is similar to the **U.S.** injury death rate over the past 10 years. The injury death rate in **Idaho** has not changed significantly since 2007.¹



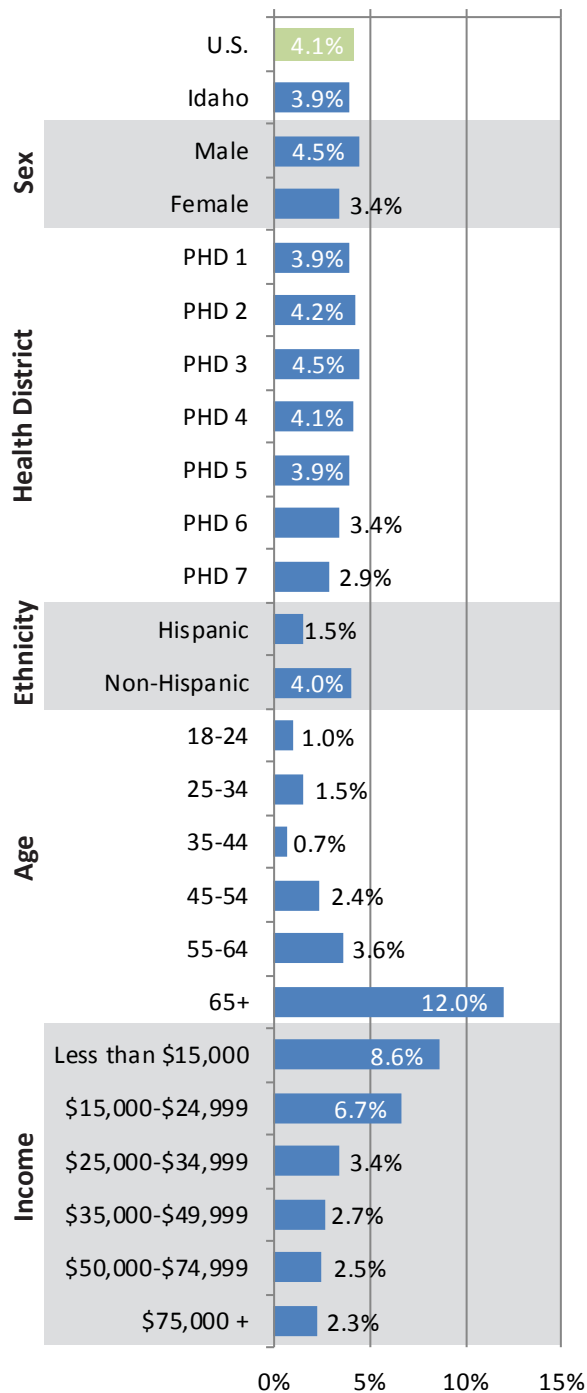
1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2017.

Topic Area: Chronic Disease

Indicator: Coronary heart disease prevalence, 2016

The prevalence of coronary heart disease

among **Idaho adults** is slightly lower than the **U.S.** median. Some significant differences exist among demographic groups, particularly by age and income.¹



How Many Adults?

48,900

4% of Idaho adults have been told by a health professional they have coronary heart disease

Who Are They?

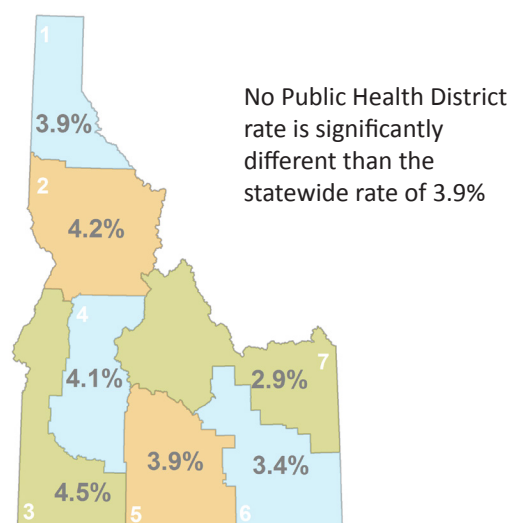
Income Below \$35,000

6% vs. 3% for incomes \$35,000 or higher

Older Adults (65+ years)

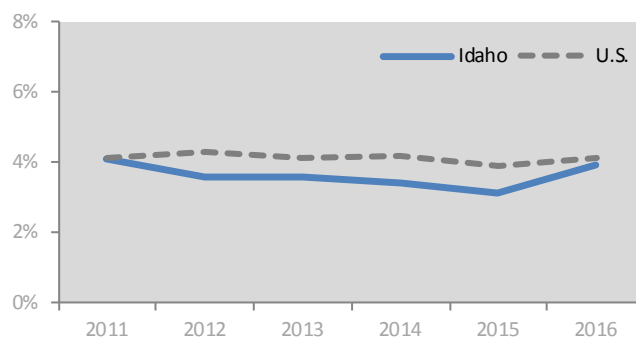
Adults age 65 and older are significantly more likely to be told they have coronary heart disease

Where Are They?



2011-2016

The percentage of adults in **Idaho** who have been told they have heart disease has remained relatively unchanged since 2011. Idaho's heart disease prevalence has been the same or slightly lower than the **U.S.** median over the past 6 years.¹

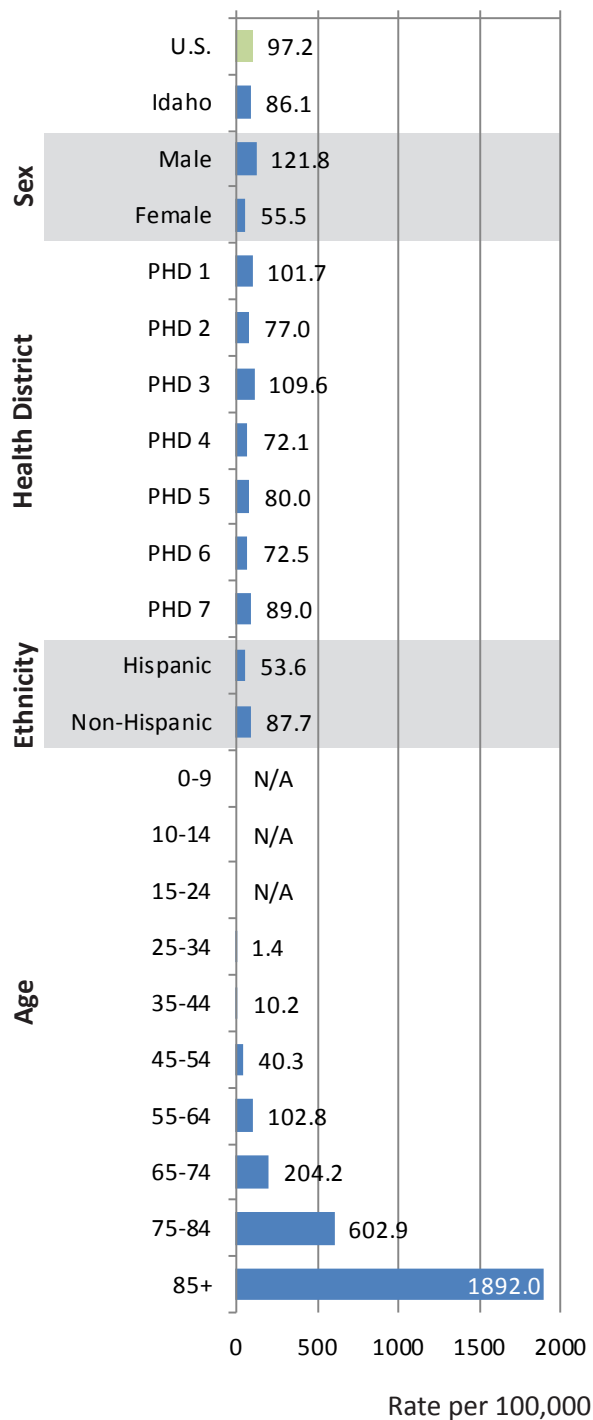


1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Chronic Disease

Indicator: Coronary heart disease death rate, 2016

The rate of coronary heart disease deaths among **Idahoans** does not differ significantly from the **U.S.** rate. Older adults are significantly more likely to die from coronary heart disease.¹



How Many Adults?

1,609

Idahoans died from heart disease (86 per 100,000) in 2016

Who Are They?

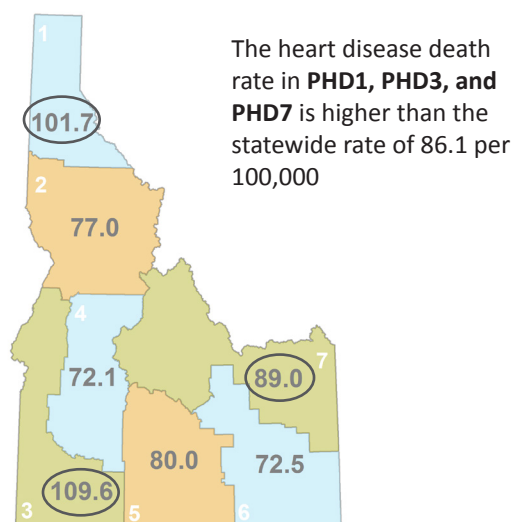
Males

122 per 100,000 males vs. 56 per 100,000 females died from heart disease

Older Adults (65+ years)

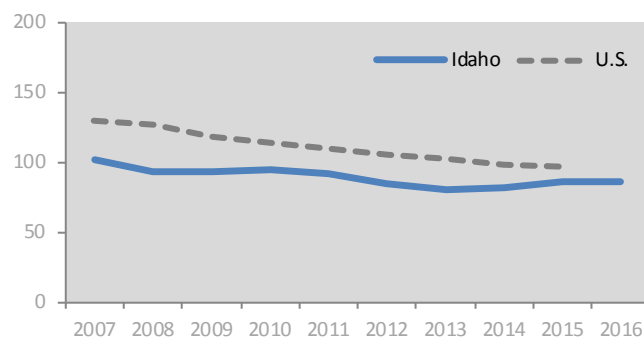
Heart disease death rate increases significantly with age

Where Are They?



2007-2016

The heart disease death rate in **Idaho** has decreased significantly since 2007. Idaho's heart disease death rate has also been significantly lower than the **U.S.** rate over the past 10 years.¹

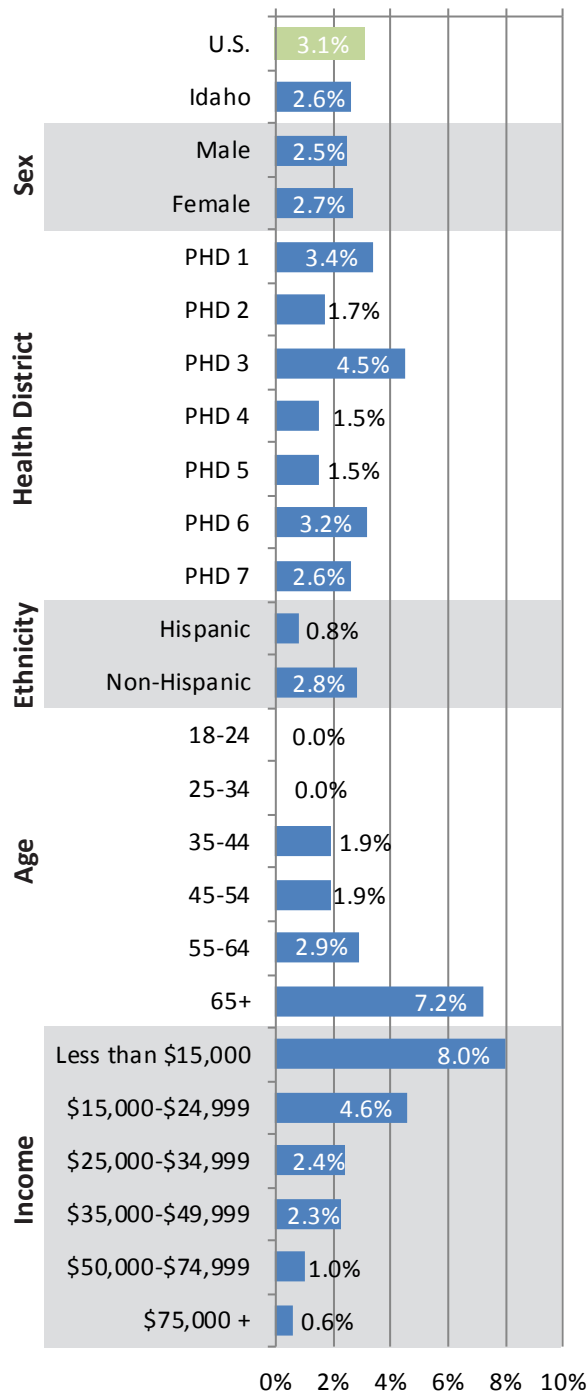


1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2017.

Topic Area: Chronic Disease

Indicator: Stroke prevalence, 2016

Stroke prevalence among **Idaho adults** is slightly lower than the **U.S.** median. Some significant differences exist among demographic groups, particularly by age and income.¹



How Many Adults?

32,100

3% of Idaho adults have had a stroke

Who Are They?

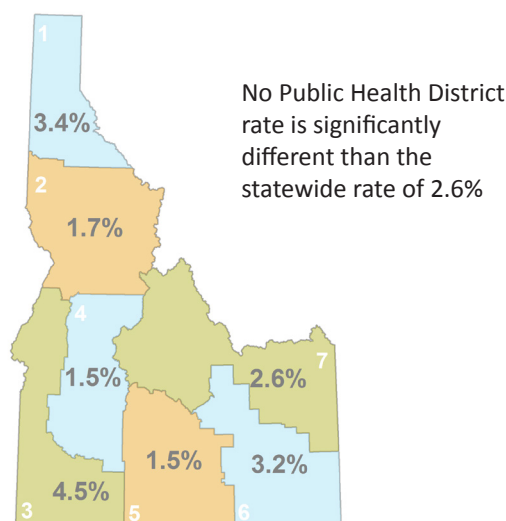
Older Adults (65+ years)

Adults age 65 and older are more likely to have had a stroke

Income Below \$35,000

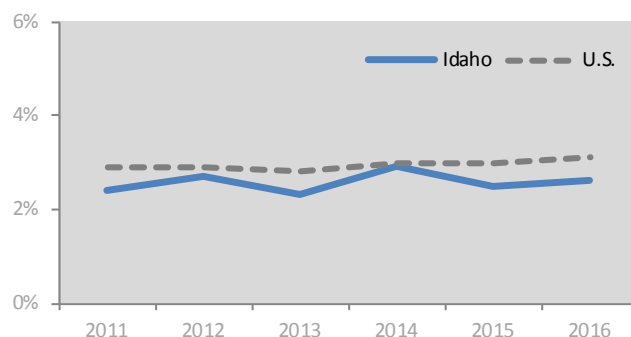
Are more likely to have had a stroke

Where Are They?



2011-2016

The percentage of adults in **Idaho** who have ever had a **stroke** has remained relatively unchanged since 2011. Idaho's heart disease prevalence has been lower than the **U.S.** rate since 2011.¹

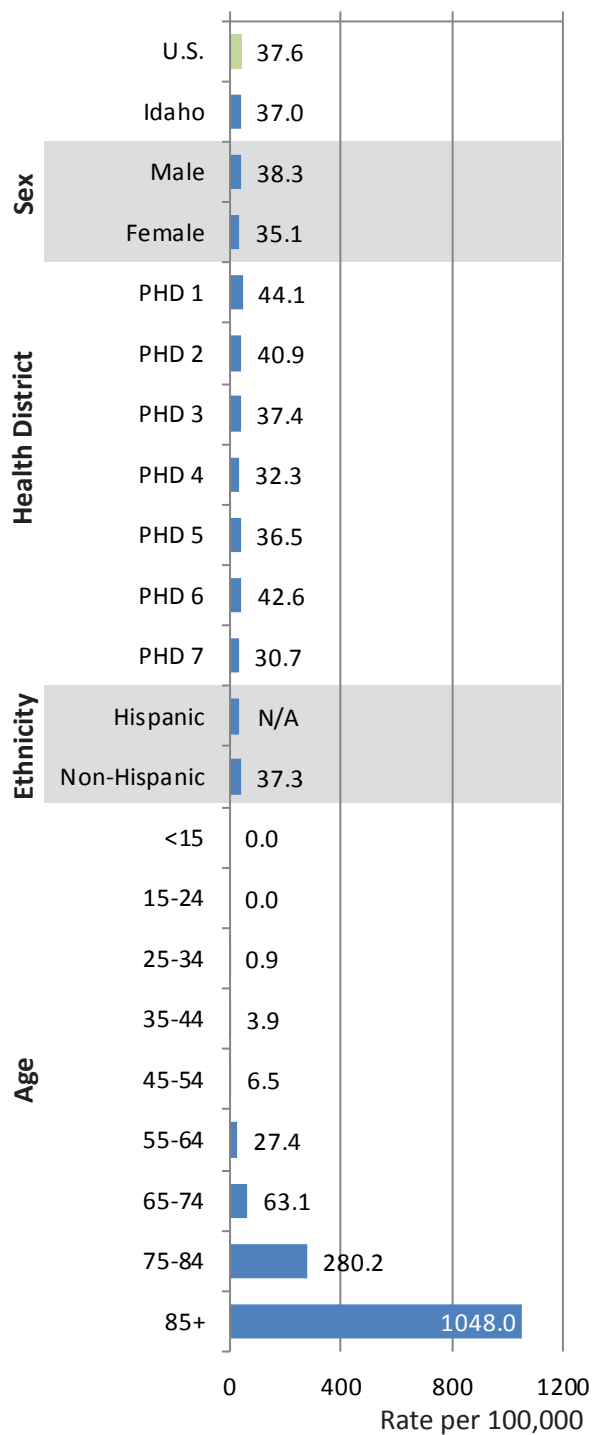


1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Chronic Disease

Indicator: Stroke death rate, 2016

The rate of stroke deaths among Idahoans does not differ significantly from the U.S. rate. The age-specific stroke death rate increases significantly with age.¹



How Many Adults?

679

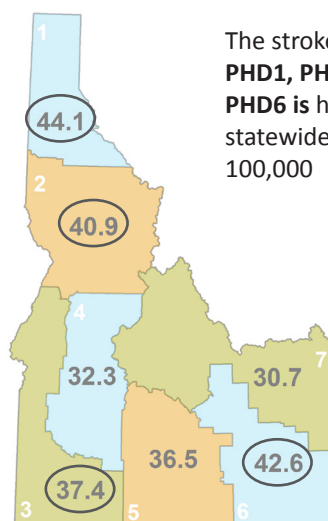
Idahoans died from a stroke (37 per 100,000) in 2016

Who Are They?

Older Adults (65+ years)

Stroke death rate increases significantly with age

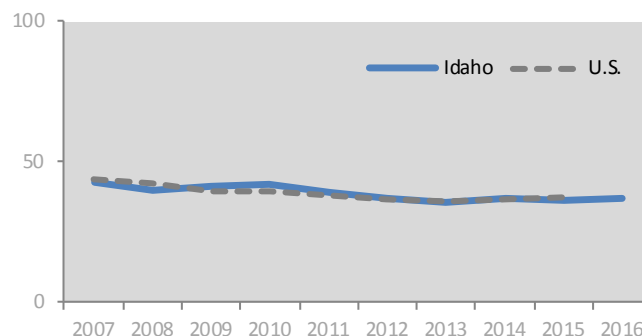
Where Are They?



The stroke death rate in PHD1, PHD2, PHD3, and PHD6 is higher than the statewide rate of 37.0 per 100,000

2007-2016

The stroke death rate in Idaho has decreased steadily since 2007. Idaho's stroke death rate has not differed significantly from the U.S. rate over the past 10 years.

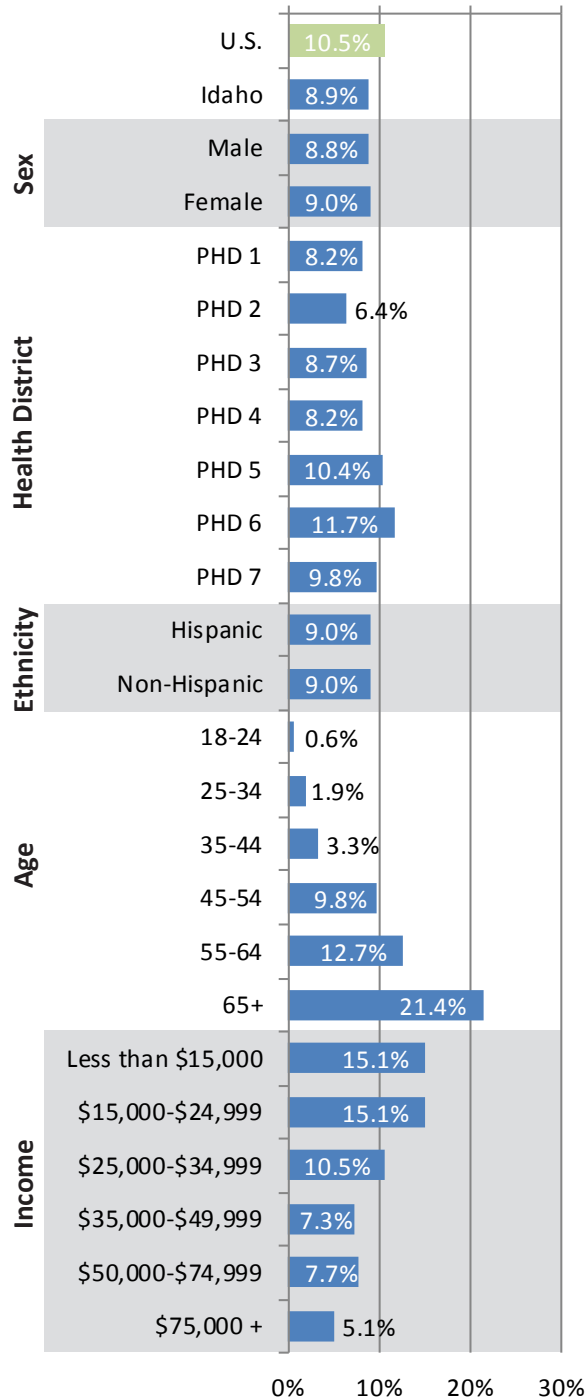


1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2017.

Topic Area: Chronic Disease

Indicator: Percentage of adults who have been diagnosed with diabetes, 2016

The percentage of adults diagnosed with diabetes in Idaho is slightly lower than the **U.S. median**. Some significant differences exist among demographic groups, particularly by age and income.¹



How Many Adults?

111,500

9% of Idaho adults have been diagnosed with diabetes

Who Are They?

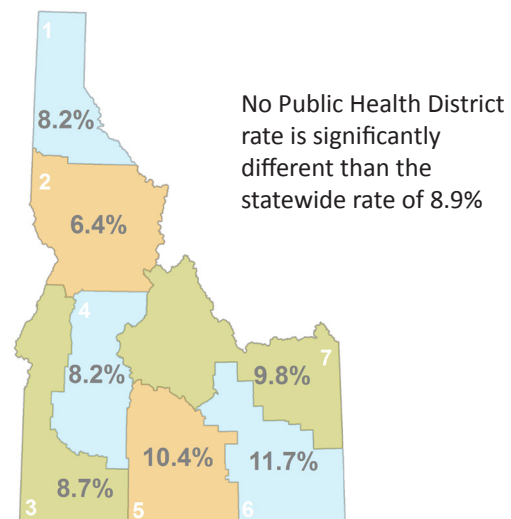
Older Adults (65+ years)

The risk for diabetes increases significantly with age

Income Below \$35,000

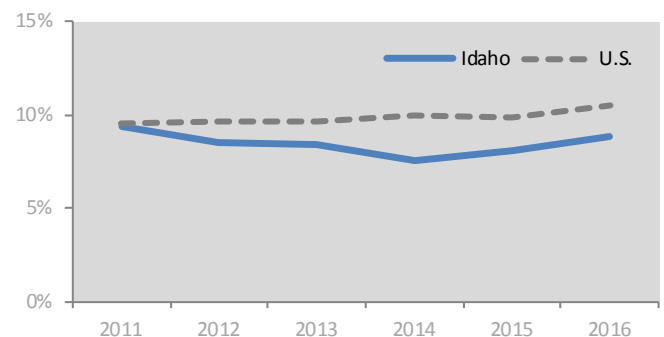
14% vs. 7% among adults with income of less than \$35,000

Where Are They?



2011-2016

The percentage of adults in **Idaho** who have ever been diagnosed with diabetes remained unchanged from 2011 to 2016. Idaho's diabetes prevalence has been lower than the **U.S. median** since 2011.¹

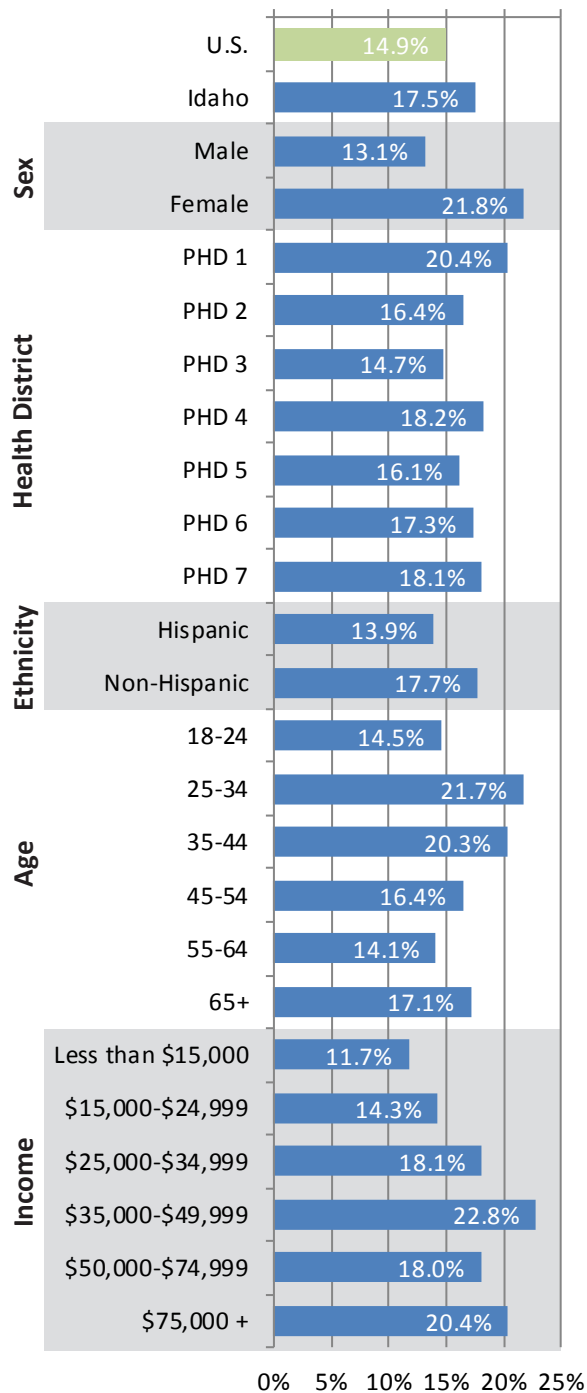


1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Health Status/Behaviors

Indicator: Percentage of adults who consume 5 or more servings of fruits and vegetables a day, 2015

The percentage of **Idaho adults** who consume **5 or more servings of fruits and vegetables a day** is higher than the **U.S.** median. Some differences exist among demographic groups, particularly by sex and income.¹



How Many Adults?

198,000

18% of Idaho adults consume 5 or more servings of fruits and vegetables a day

Who Are They?

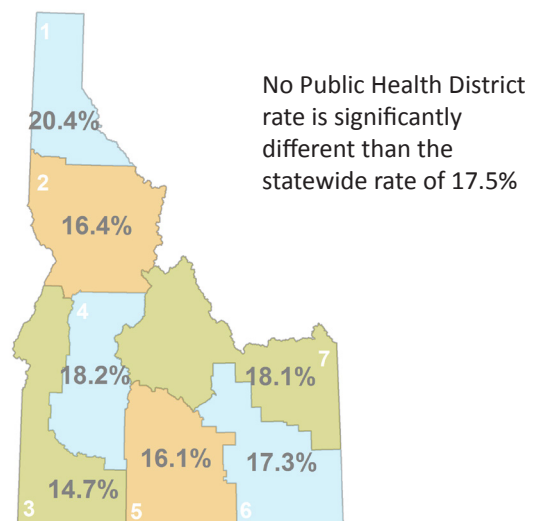
Females

22% vs. 13% of males consume 5 or more servings of fruit and vegetables a day

Income Above \$35,000

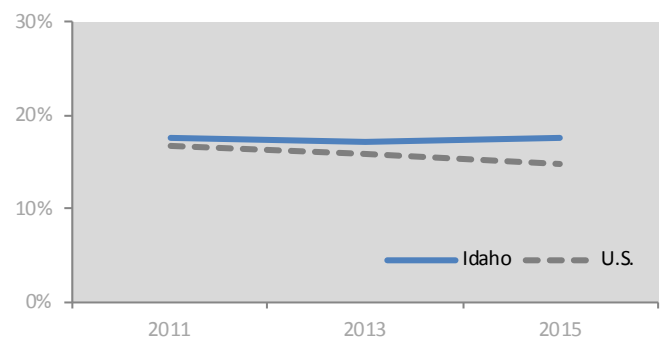
20% vs. 15% among adults with income of less than \$35,000

Where Are They?



2011-2015

The percentage of adults in **Idaho** who consume 5 or more servings of fruits and vegetables a day did not change significantly between 2011 and 2015.¹



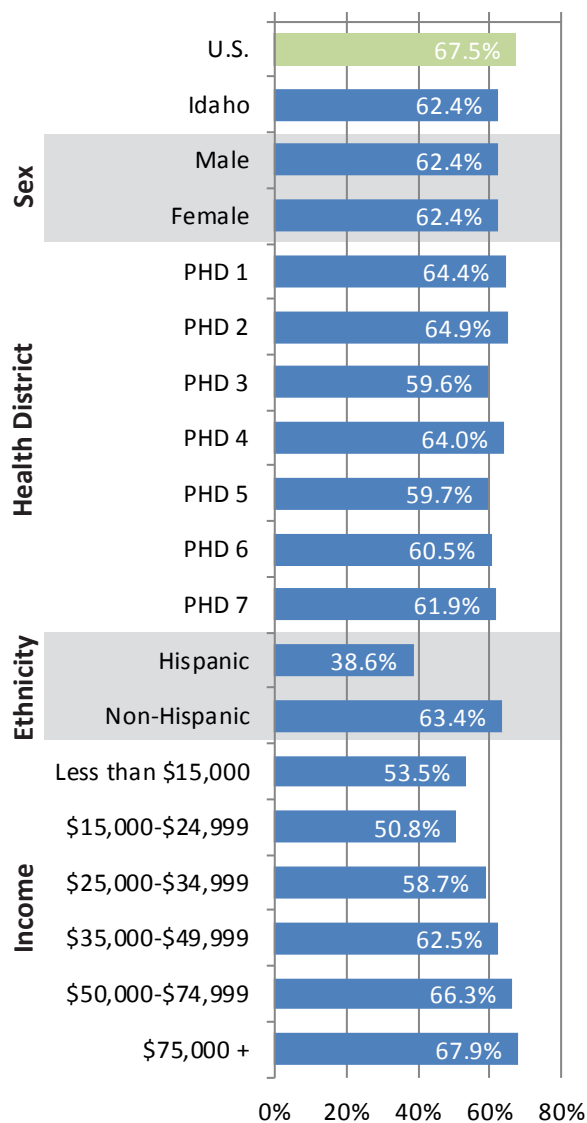
Fruit and vegetable consumption questions are asked in odd-numbered years only.

1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Health Status/Behaviors

Indicator: Percentage of adults aged 50-75 who had colorectal cancer screening, 2016

The percentage of **Idaho adults** (age 50-75) who had colorectal cancer screening is lower than the **U.S.** median. Some significant differences exist among demographic groups, particularly by household income and Hispanic ethnicity.¹



How Many Adults?

271,300

62% of Idaho adults (aged 50-75 years) have been screened for colorectal cancer

Who Are They?

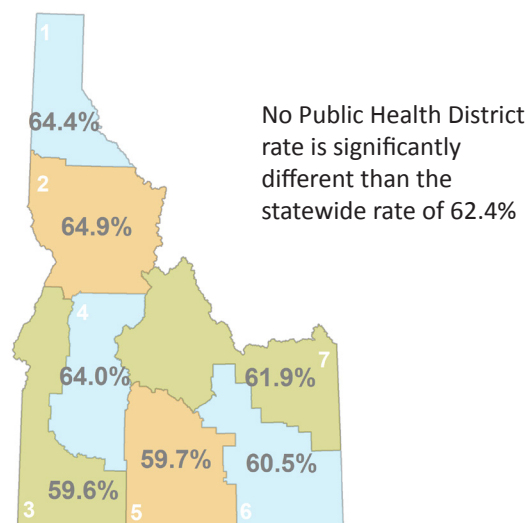
Hispanic Adults

39% vs. 63% non-Hispanic adults have been screened for colorectal cancer

Income Below \$35,000

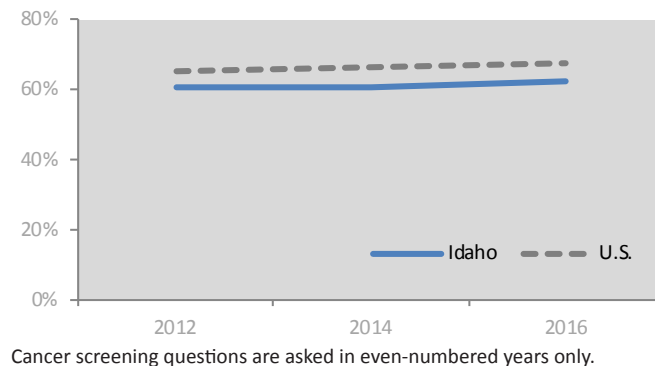
54% compared to 66% among households earning \$35,000 or more

Where Are They?



2012-2016

The percentage of adults in **Idaho** who have received colorectal cancer screening did not change significantly between 2012 and 2016¹

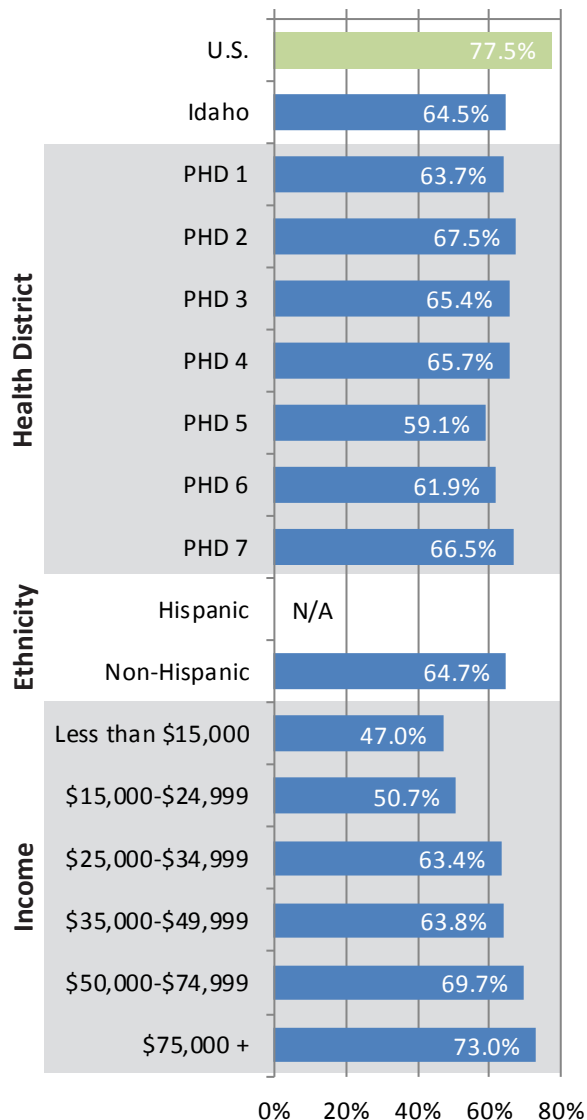


1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Health Status/Behaviors

Indicator: Percentage of women aged 50-74 who had a breast cancer screening according to the most recent guidelines, 2016

The percentage of women (age 50-74) who had a breast cancer screening according to the most recent guidelines in Idaho is markedly lower than the U.S. median.



How Many Women?

144,000

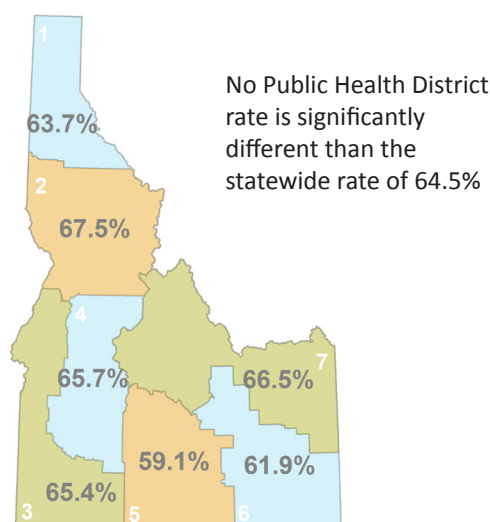
65% of female adults in Idaho (aged 50-74 years) have been screened for breast cancer based on the most recent guidelines

Who Are They?

Lower Income Females

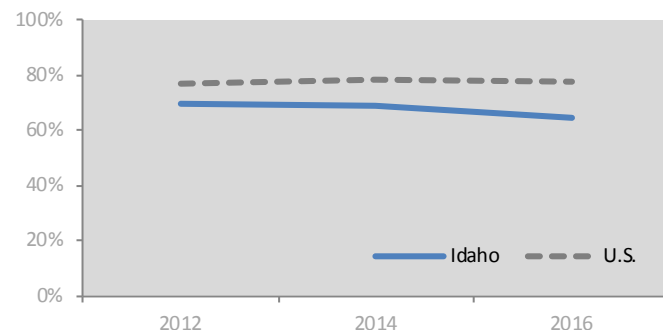
Are less likely to have been screened for breast cancer

Where Are They?



2012-2016

The percentage of adult females in Idaho who have received breast cancer screening did not change significantly between 2012 and 2016. Idaho's breast cancer screening rates were lower than the U.S. median for 2012 to 2016.¹



Cancer screening questions are asked in even-numbered years only.

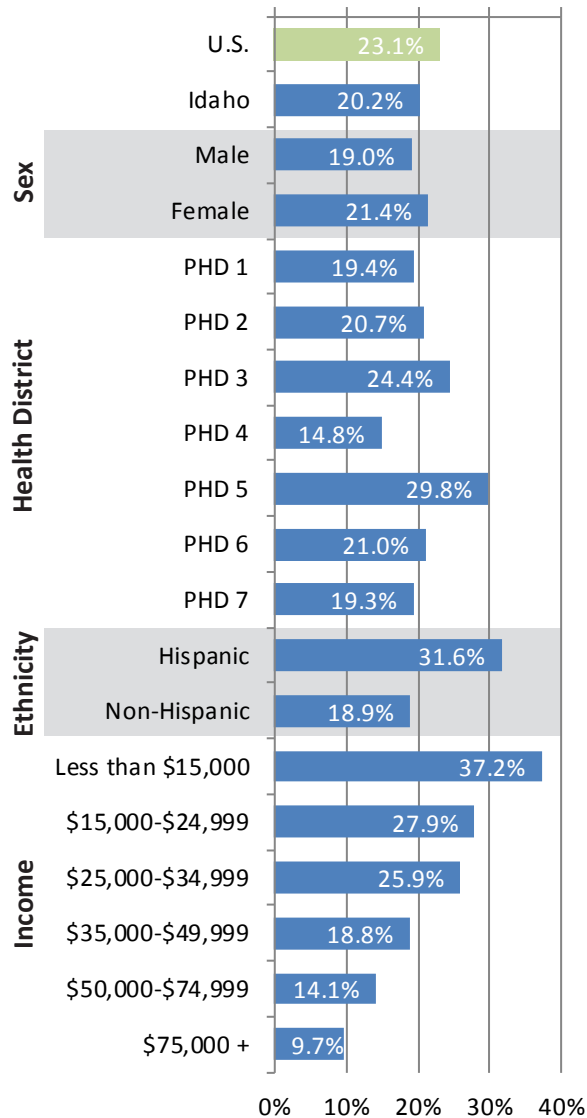
1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Health Status/Behaviors

Indicator: Percentage of adults with no leisure time physical activity, 2016

The prevalence of **Idaho adults** with no leisure time physical activity is lower than the **U.S.** median.

Some significant differences exist among demographic groups, particularly by income and Hispanic ethnicity.¹



How Many Adults?

252,000

20% of Idaho adults did **not** participate in leisure time physical activity

Who Are They?

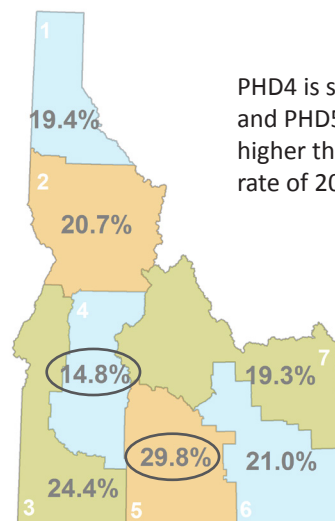
Hispanic Adults

32% vs. 19% of non-Hispanic adults did **not** participate in leisure time physical activity

Lower Income Adults

Are more likely to report they do not participate in leisure time physical activity

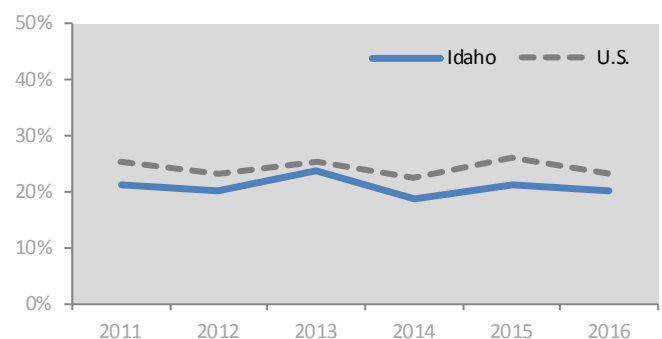
Where Are They?



PHD4 is significantly lower and PHD5 is significantly higher than the statewide rate of 20.2%

2011-2016

The percentage of adults in **Idaho** with no leisure time physical activity did not change significantly between 2011 and 2016.¹

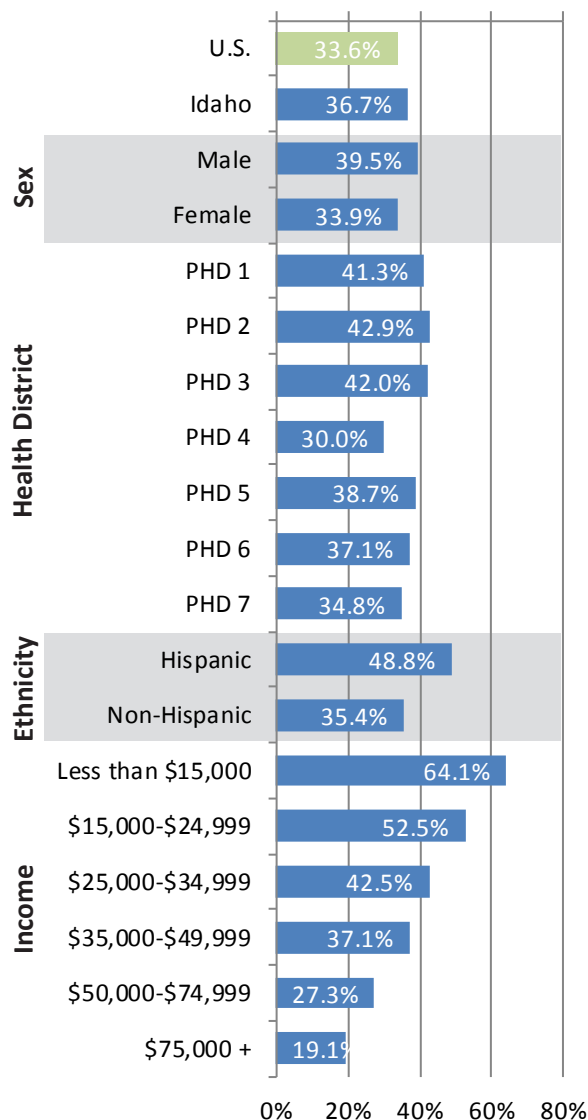


1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Health Status/Behaviors

Indicator: Percentage of adults who did not visit the dentist in the past 12 months, 2016

The prevalence of **Idaho adults** who did not visit the dentist in the past 12 months is slightly higher than the **U.S.** median. Some significant differences exist among demographic groups, particularly by sex, income, and Hispanic ethnicity.¹



How Many Adults?

455,900

37% of Idaho adults did not visit a dentist in the past 12 months

Who Are They?

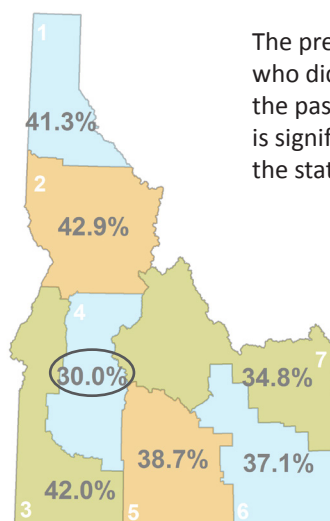
Hispanic Adults

49% vs. 35% non-Hispanic adults have not visited a dentist in the past 12 months

Income Below \$35,000

52% vs. 27% adults with household income greater than \$35,000 visited a dentist in the past 12 months

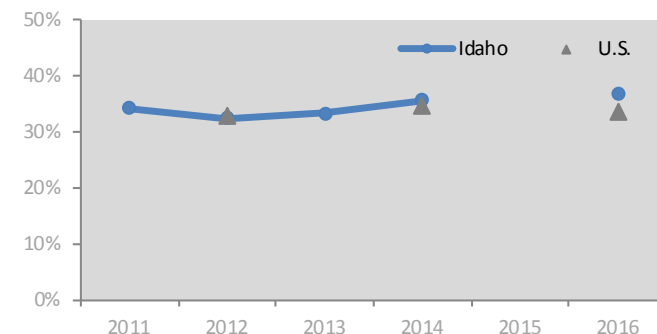
Where Are They?



The prevalence of adults who did **not** visit a dentist in the past 12 months in **PHD4** is significantly lower than the statewide rate of 36.7%

2011-2016

The percentage of adults in **Idaho** who did not visit a dentist during the past 12 months increased significantly between 2011 and 2016.¹



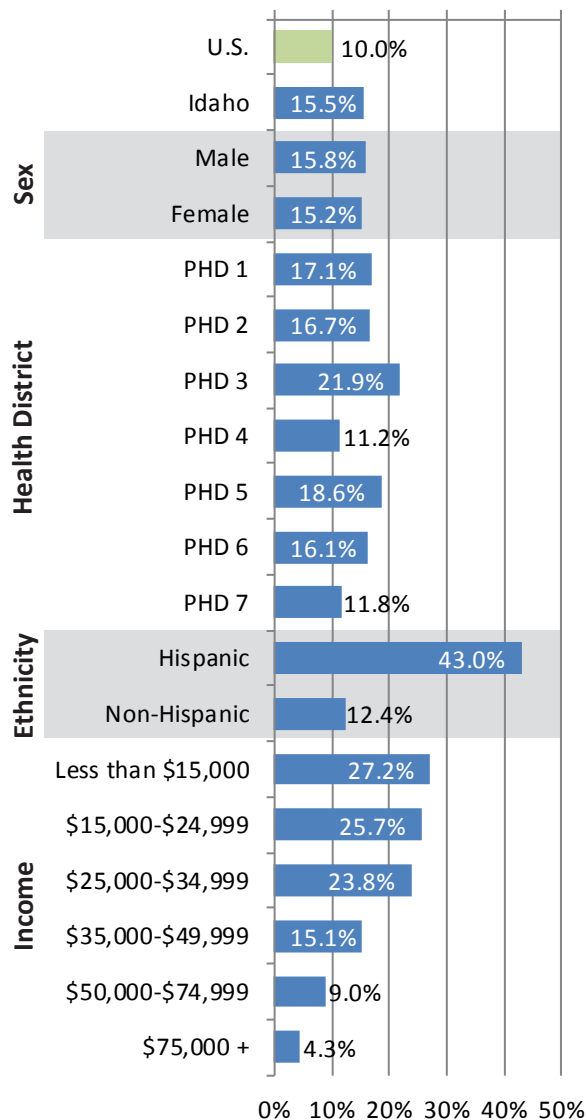
The question about dentist visits was not asked in 2015.

1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Access/Systems

Indicator: Percentage of adults without healthcare coverage, 2016

The prevalence of **Idaho adults** who are **without healthcare coverage** is higher than the **U.S.** median. Some significant differences exist among demographic groups, particularly by income and Hispanic ethnicity.¹



How Many Adults?

192,700

16% of Idaho adults do not have healthcare coverage

Who Are They?

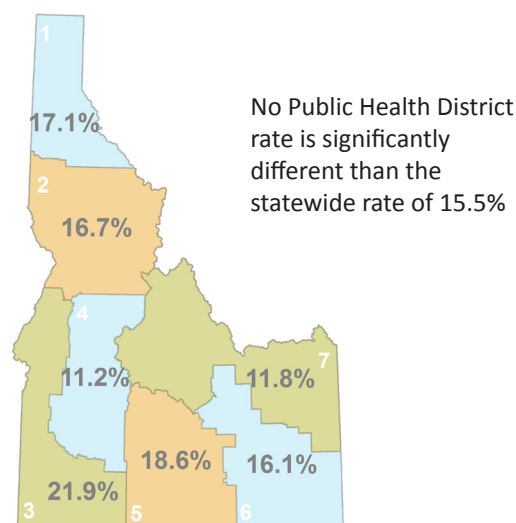
Hispanic Adults

43% vs. 12% non-Hispanic adults do not have healthcare coverage

Lower Income Adults

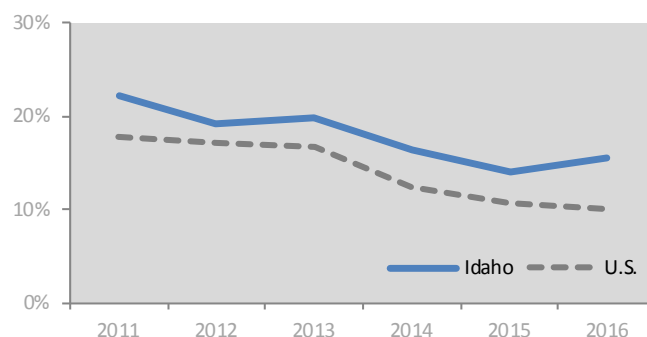
Are significantly less likely to have healthcare coverage

Where Are They?



2011-2016

The percentage of adults in **Idaho** who do not have **healthcare coverage** decreased significantly between 2011 and 2016.¹

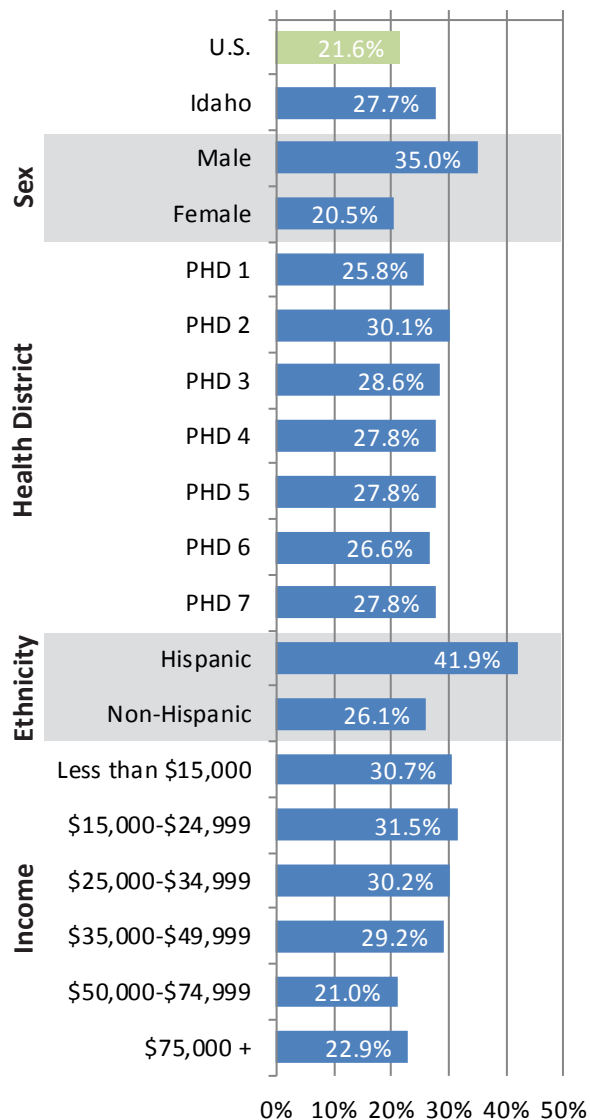


1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017

Topic Area: Access/Systems

Indicator: Percentage of adults without a usual healthcare provider, 2016

The prevalence of **Idaho adults** who do not have a usual healthcare provider is higher than the **U.S.** median. Some significant differences exist among demographic groups, particularly by sex, income and Hispanic ethnicity.¹



How Many Adults?

343,000

28% of Idaho adults do not have a usual healthcare provider

Who Are They?

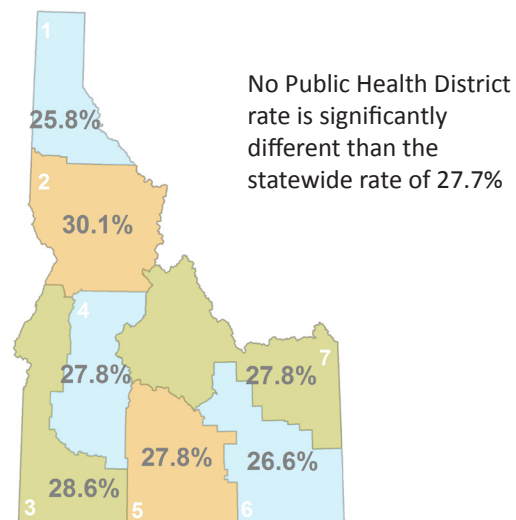
Hispanic Adults

42% vs. 26% non-Hispanic adults do not have a usual healthcare provider

Males

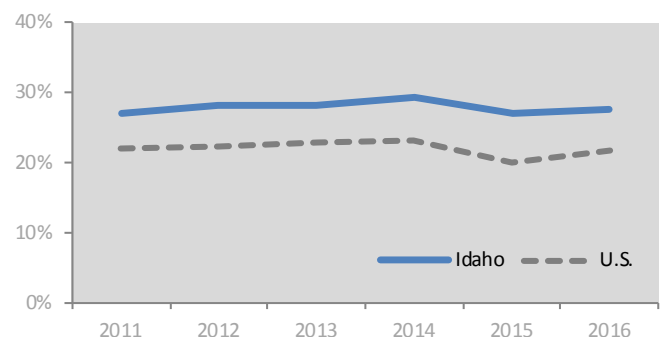
35% vs. 21% of females do not have a usual healthcare provider

Where Are They?



2011-2016

The percentage of adults in **Idaho** who do not have a usual healthcare provider remained unchanged between 2011 and 2016.¹



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

Topic Area: Access/Systems

Indicator: Rate of active primary care physicians per 100,00 population, 2016

Primary Care Physicians

Idaho ranked 46th (i.e., 4th lowest among all 50 states) for the number of active primary care physicians (73.1 per 100,000 population).¹

Less than one percent (0.3%) of medical school students report they “hope to work” in Idaho after completing their medical training.¹

The percentage of Idaho land mass designated as a Health Professional Shortage Area (HPSA):¹

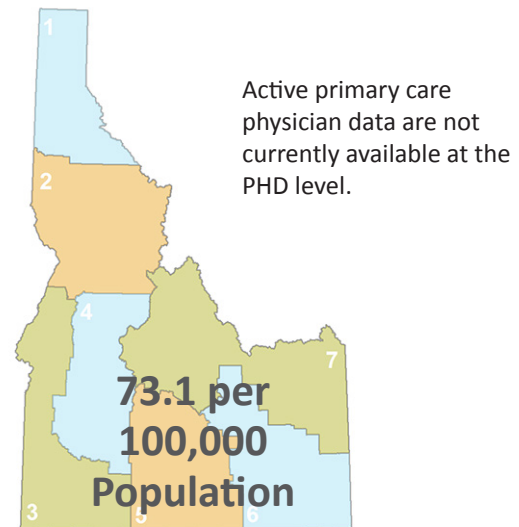
Primary Care HPSA:	96%
Dental HPSA:	97%
Mental HPSA:	100%

How Many Primary Care Physicians?

1,231

Active primary care physicians in Idaho

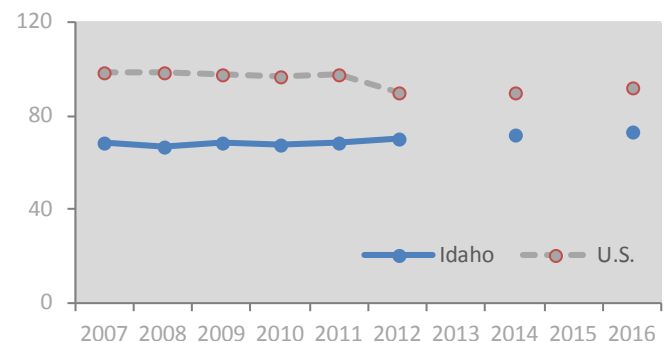
Where Are They?



2007-2016

The rate of active primary care physicians (per 100,000)

has remained unchanged since 2007. Idaho's active primary care physician rate has been significantly lower than the U.S. rate over the past 10 years.¹

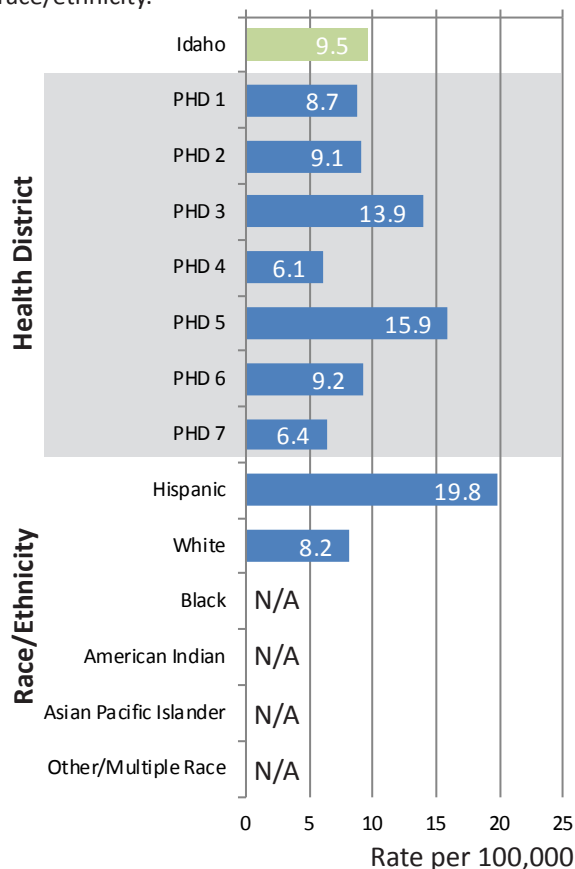


1. Association of American Medical Colleges. 2017 State Physician Workforce Data Book, 2017.

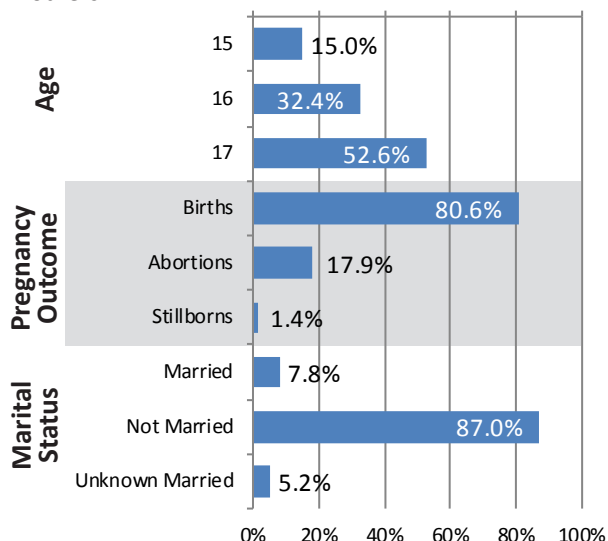
Topic Area: Reproductive Health

Indicator: Adolescent pregnancy rates (ages 15-17), 2016

The rate (per 1,000 females) of teen pregnancy among Idaho females age 15-17 varies among race/ethnicity.¹



The majority of teen pregnancies (age 15-17) are among 17 year old females (53%). Most teen pregnancies result in a live birth (81%) and more than three-fourths (87%) of births occur to unmarried teen mothers.



How Many Adolescent Females?

349

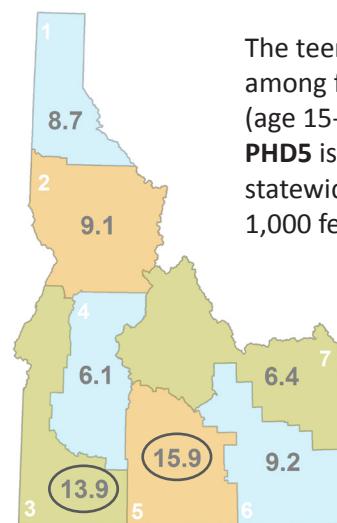
Idaho teens (age 15-17) became pregnant in 2016

Who Are They?

American Indian Teens

12 (per 1,000 females) vs. 8 (per 1,000 females) among White non-Hispanic female teens (age 15-17) became pregnant

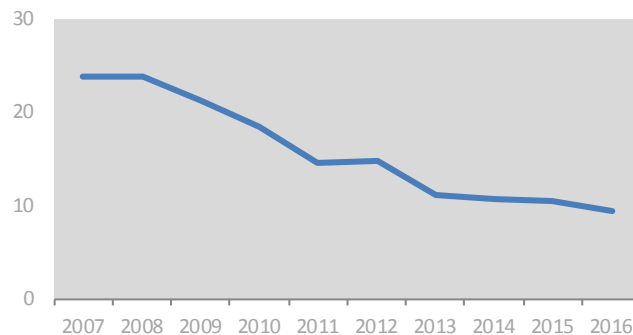
Where Are They?



The teen pregnancy rate among female teens (age 15-17) in **PHD3** and **PHD5** is higher than the statewide rate of 9.5 per 1,000 females.

2007-2016

The teen pregnancy rate in Idaho decreased significantly between 2007 and 2016.¹

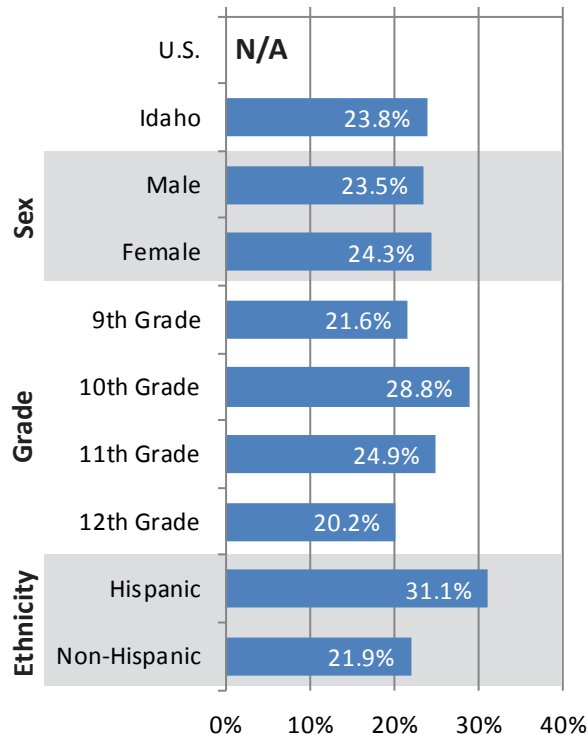


1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2017.

Topic Area: Reproductive Health

Indicator: Percentage of adolescents that had sexual intercourse for the first time at 15 years old or younger, 2017

The percentage of Idaho students who had sexual intercourse for the first time at age 15 or younger varies by grade level and Hispanic ethnicity.



How Many Adolescents?

21,400

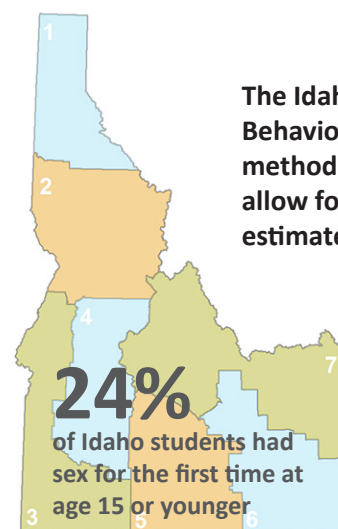
24% of Idaho adolescents (grades 9-12) had sexual intercourse for the first time at age 15 or younger

Who Are They?

Hispanics

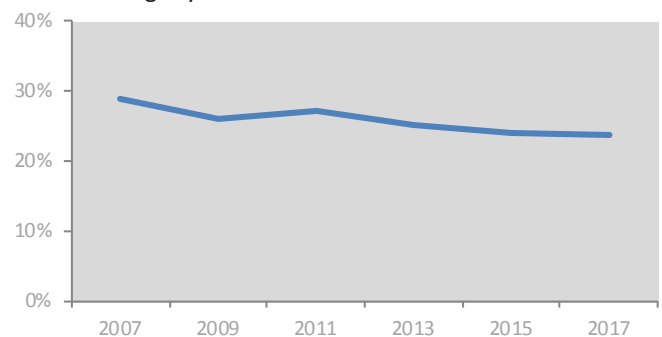
31% vs. 22% among non-Hispanic students had sexual intercourse for the first time at age 15 or younger

Where Are They?



2007-2017

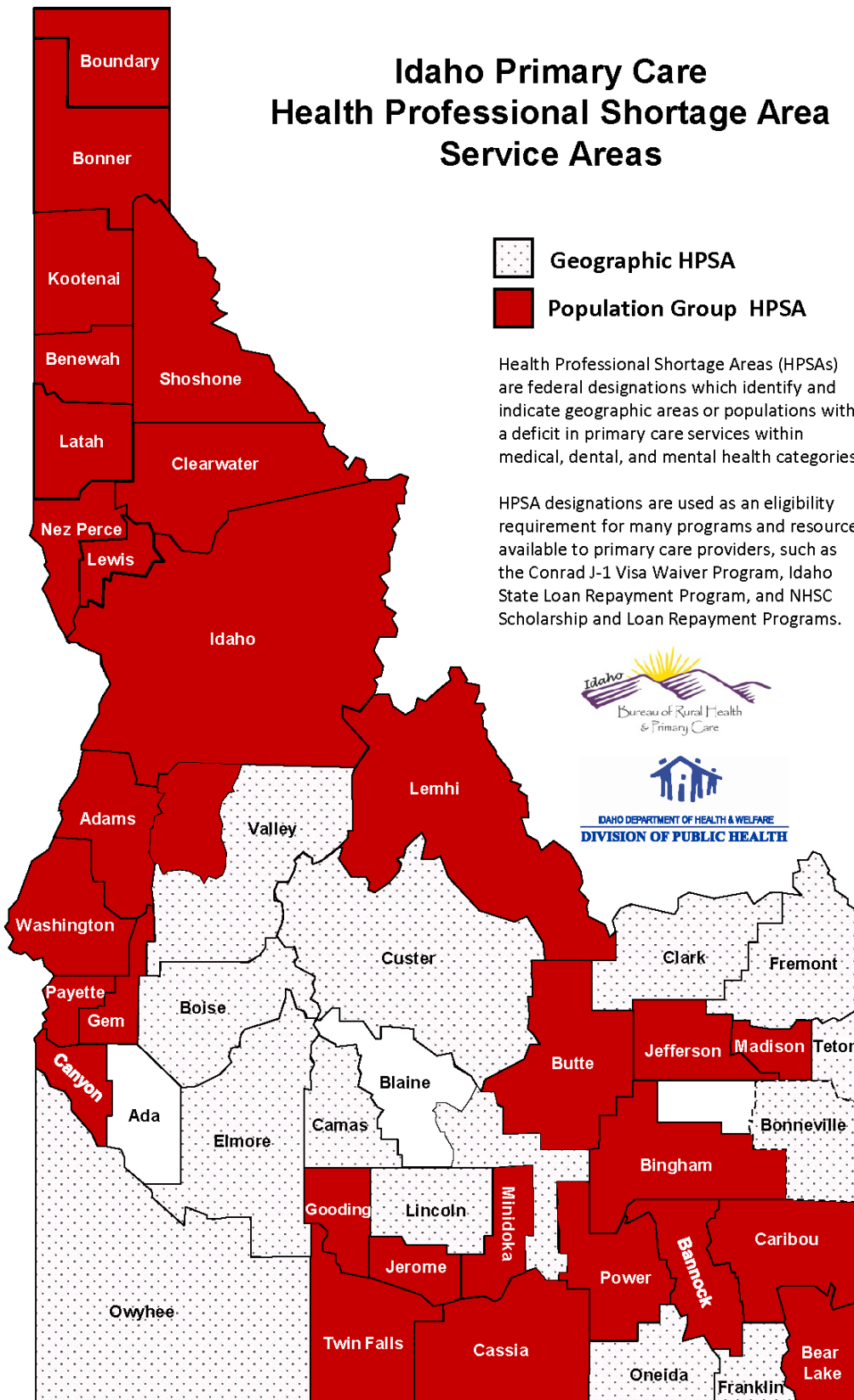
The percentage of adolescents in Idaho who had sexual intercourse for the first time at age 15 years or younger decreased slightly between 2007 and 2017.¹



Health Professional Shortage Area Maps

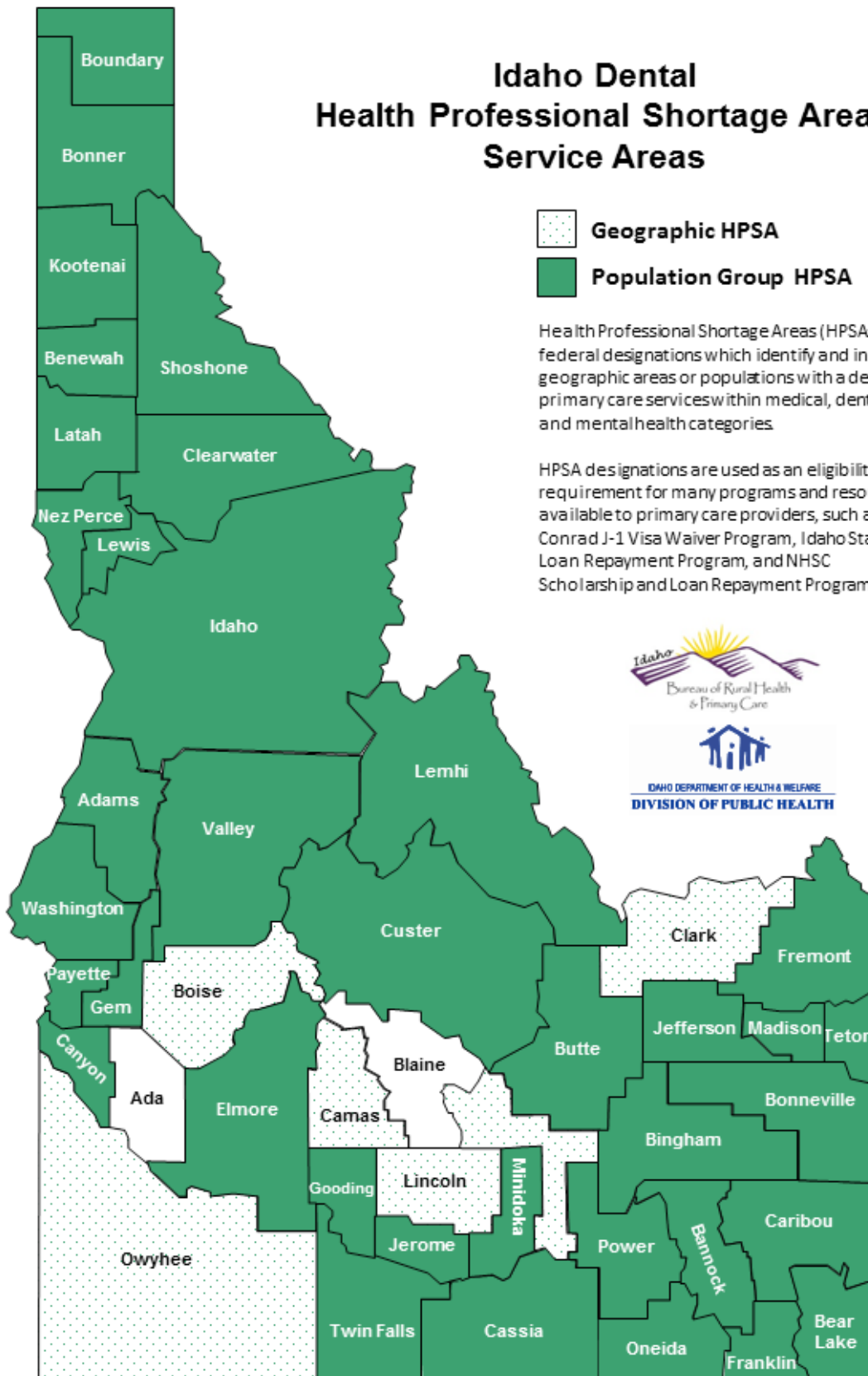


IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH



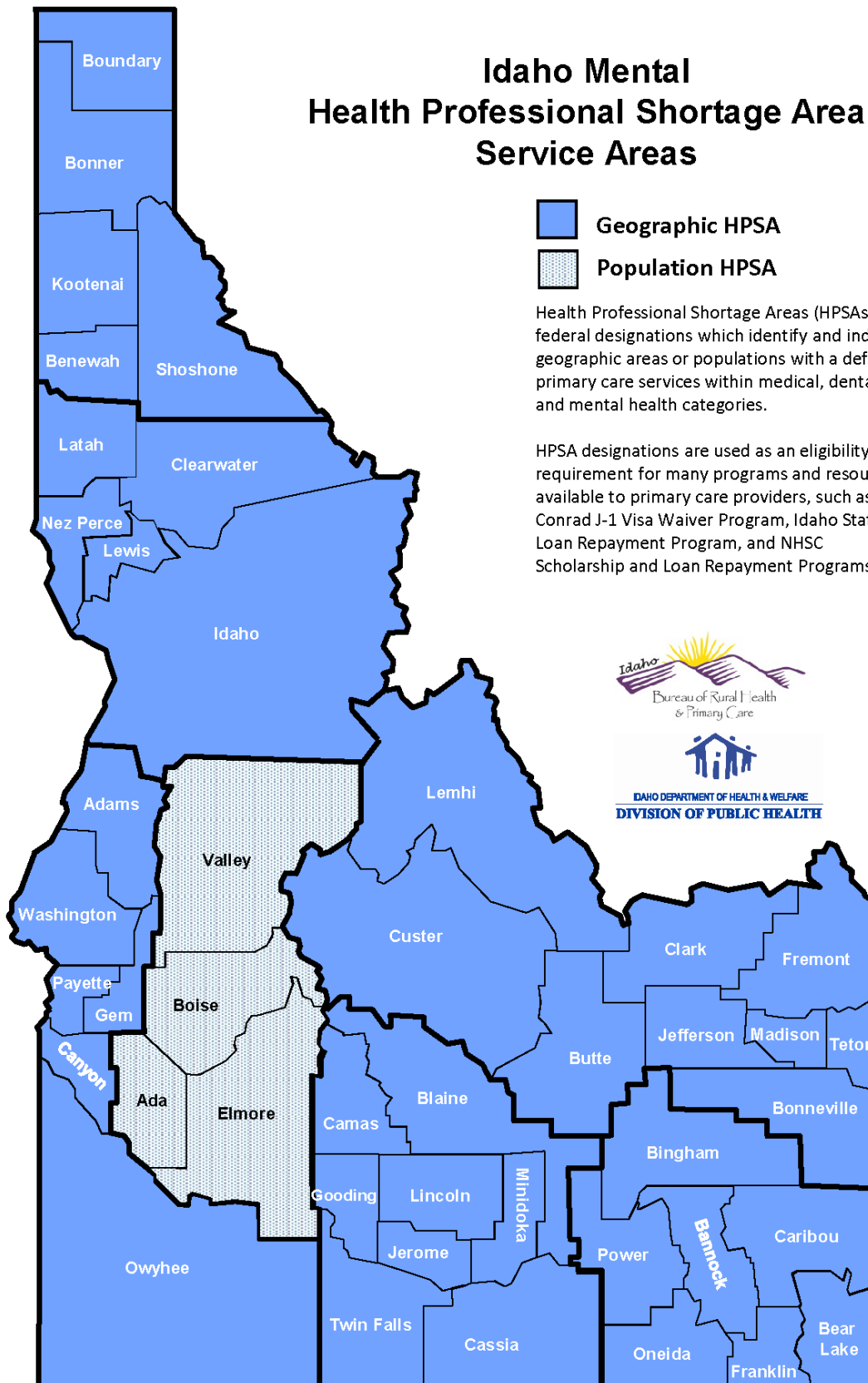
Bureau of Rural Health and Primary Care, Division of Public Health, Department of Health and Welfare, 12/12/17 – please contact (208) 334-5993 for updates

Idaho Dental Health Professional Shortage Area Service Areas



Bureau of Rural Health and Primary Care, Division of Public Health, Department of Health and Welfare, 12/12/17 – please contact (208) 334-5993 for updates

Idaho Mental Health Professional Shortage Area Service Areas

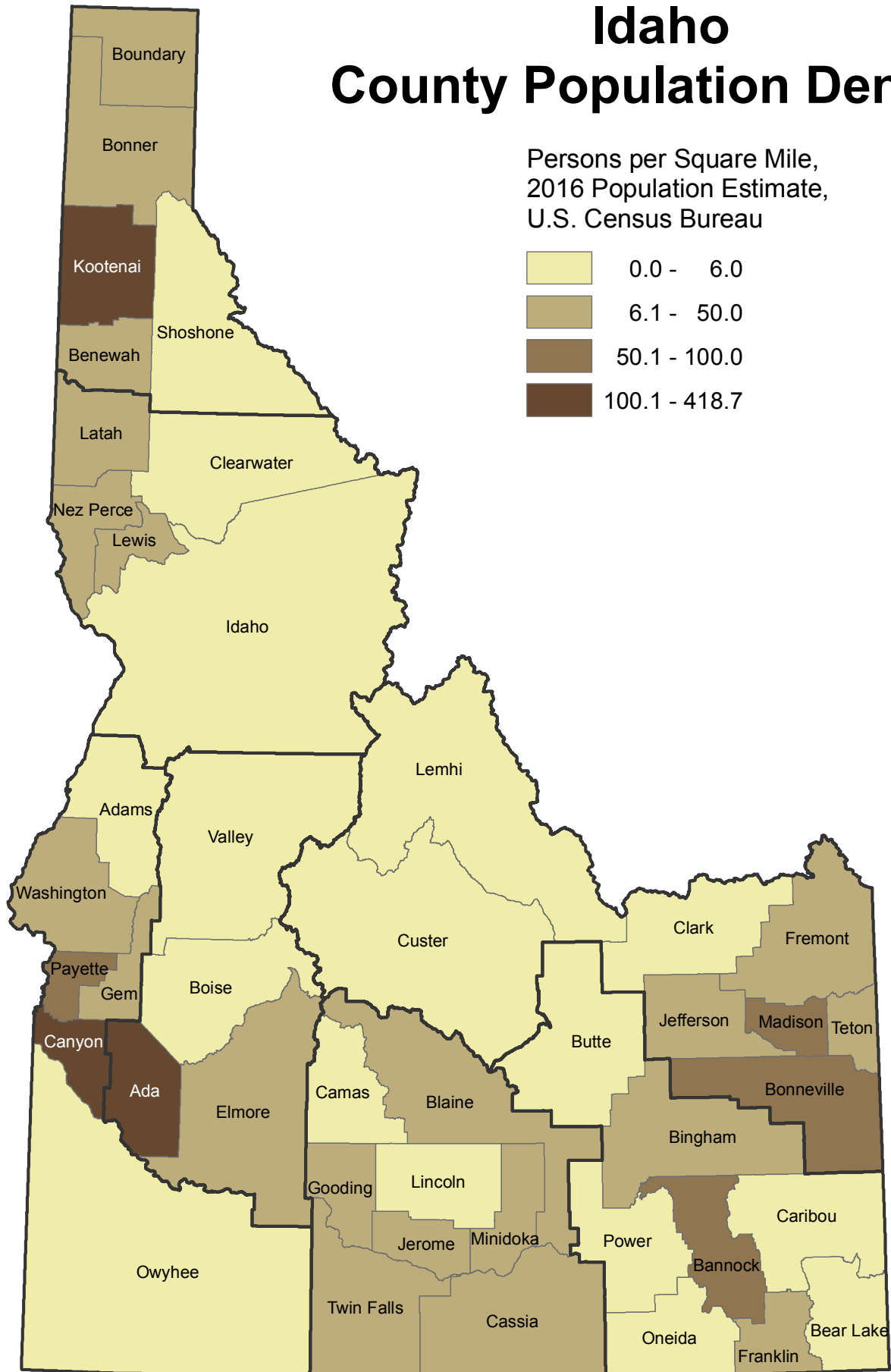
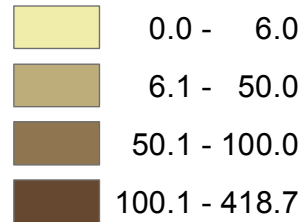


Bureau of Rural Health and Primary Care, Division of Public Health, Department of Health and Welfare, 12/12/17 – please contact (208) 334-5993 for updates

Idaho

County Population Density

Persons per Square Mile,
2016 Population Estimate,
U.S. Census Bureau



Plan for Improving Population Health Progress Reports, 2016-2017



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Progress Report for 2017 Strategies and Measures

Introduction:

This section is an update on the status of strategies and measures selected for *Get Healthy Idaho: Measuring and Improving Population Health* (January, 2017). The health priorities selected were access to care, diabetes, tobacco, and obesity. Over the past year and a half, work on these strategies crossed multiple bureaus and divisions within the Department of Health and Welfare and involved partnerships from outside of the Department. Progress towards reaching the target of each measure is reported in the "Actual" column on the following tables.



Health Priority: ACCESS TO CARE
Five Year Goal: Increase access to healthcare services
SMART Objective: Initiate three efforts to identify or address barriers facing Idaho's underserved areas and populations by December 2016

CY = Calendar Year
SFY = State Fiscal Year

Strategy 1: Review and renew healthcare shortage areas to maximize funding and healthcare provider recruitment efforts in rural and frontier counties.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of currently designated areas reviewed annually as dental, mental, primary care Health Professional Shortage Areas	46 per year	46	58	Met
Strategy 2: Develop and implement virtual patient-centered medical homes (PCMH) through Community Health EMS (CHEMS), community health workers (CHWs), and Telehealth.				
Measure 1:	Baseline	Target	Actual	Met/Unmet
Number of Idaho EMS agencies recruited to participate in the CHEMS initiative	2 (CY2015)	13	9 (6/30/2017)	Unmet
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of Idaho EMS agencies providing CHEMS services	1 (CY2015)	13	4 (6/30/2017)	Unmet
Measure 3:	Baseline	Target	Actual	Met/Unmet
Number of CHWs trained through Idaho State University program	0 (CY2015)	75	34 (6/30/2017)	Unmet
Measure 4:	Baseline	Target	Actual	Met/Unmet
Number of telehealth programs established in PCMHs	0 (CY2015)	12	3	Unmet
Strategy 3: Recruit new and existing PCMH's to participate in the SHIP.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of primary care clinics recruited to participate in the SHIP PCMH transformation	13 (CY2015)	55	110 (6/30/2017)	Met
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of RCs	0 (CY2015)	7	7 (6/30/2017)	Met

Summary of the work completed to date:

Health Professional Shortage Areas (HPSAs) are federal designations that indicate healthcare provider shortages in primary care, dental health, and mental health. The DPH's Bureau of Rural Health and Primary Care is responsible for designating, updating and managing HPSAs in Idaho according to federal guidelines. In 2016, 93 areas in Idaho were designated as a HPSA. Currently, 47 areas qualify as medically underserved (MUA) or as having medically underserved populations (MUP).

Seven local Emergency Medical Services (EMS) agencies sent a total of 13 students to CHEMS training in year two (2017). There are 12 students signed up for the third year from seven EMS agencies. The College of Western Idaho will be administering a Community Health EMS course for Emergency Medical Technicians (EMTs) and Advanced EMTs. There

are 20 students (from seven EMS agencies) who are interested in attending the program in 2018. Continuing education opportunities for CHEMS providers have consisted of two topical webinars with a third planned for early 2018. Planning is also underway for the first CHEMS Learning Collaborative. Boise State University and the Area Agency on Aging, under contract with the Bureau of EMS & Preparedness, developed the framework for a pilot study to test the delivery and sustainability of CHEMS in a rural community in Idaho.

Health Priority: DIABETES

Five Year Goal: Reduce the economic burden of diabetes in Idaho and improve the quality of life for those who have or are at risk for diabetes

SMART Objective: Increase by 10% the availability of educational opportunities for Idahoans to manage modifiable risk factors associated with diabetes or pre-diabetes by July 2016

Strategy 1: Increase the number of CDC-recognized Diabetes Prevention Programs (DPP) and American Diabetes Association (ADA) or American Association of Diabetic Educators (AADE) Diabetes Self-Management Education (DSME) Programs.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of ADA-recognized/AADE-accredited DSME programs	28 (SFY2015)	40	36	Unmet
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of persons with diabetes who have at least one encounter at an ADA recognized or AADE accredited program.	6,412 (CY2012)	8,400	7,994	Unmet
Strategy 2: Increase referrals to CDC-recognized Diabetes Prevention Programs and ADA/AADE Diabetes Self-Management Education Programs.				
Measure 1:	Baseline	Target	Actual	Met/Unmet
Number of persons with pre-diabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized DPP	89 (SFY2014)	320	605	Met
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of CDC-recognized or pending recognition DPPs	3 (SFY2015)	15	16	Met

Summary of the work completed to date:

The Idaho Diabetes Program has offered subgrant awards to health systems and ADA recognized/AADE accredited DSME programs to help increase the number of DSME and DPP programs available in Idaho. The increase in access to these programs is the first step to increasing participant enrollment. Although enrollment numbers were not met for strategy 2, measure 1, the Idaho Diabetes Program has developed and is beginning implementation of a social marketing plan for both DSME and DPP to increase awareness and promote attendance to these programs.

Health Priority: TOBACCO
Five Year Goal: Reduce tobacco use in Idaho
SMART Objective: Increase the percentage of Idaho adult smokers that have attempted to quit smoking in the past 12 months from 61.3% to 66.3% by July 2016

Strategy 1: Increase referrals to cessation services.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of women enrolled in Women's Health Check ages 21-64 referred to the QuitLine cessation services Note: Target is lower than baseline due to decreased enrollment for Women's Health Check services.	708 (SFY2014)	700	1,049	Met
Measure 2:	Baseline	Annual Target	Actual	Met/Unmet
Number of tobacco users who registered for Idaho QuitLine cessation services	8,142 (SFY2015)	8,956 (10% above baseline)	8,081	Unmet
Strategy 2: Promote the use of Nicotine Replacement Therapy (NRT) for appropriate individuals enrolled in cessation services.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of Idaho QuitLine registrants shipped at least 4 weeks of NRT	5,943 (SFY2015) (73% of total registrants)	6,717 (75% of target for phone and QuitLine)	5,741	Unmet
Measure 2:	Baseline	Target	Actual	Met/Unmet
Proportion of registrants ordering NRT through Idaho QuitLine cessation services	73% (SFY2015)	75%	71%	Unmet

Summary of the work completed to date:

Project Filter developed and implemented a new campaign this year, taking into account feedback from a focus group on target populations prevalent in Idaho. One of the campaign focuses was designed to reach pregnant mothers in the 18-24 age range. Project Filter has also been working with several universities in an effort to develop or strengthen tobacco policies, having a direct effect on male and female 18-24 year olds. The outcomes resulting from these efforts are increased call volume and NRT orders for the targeted age group.

Overall, 18-24 year olds are not a large proportion of callers to the Idaho QuitLine. Project Filter plans to collect and report on these same measures for next year, but expand reporting for the entire population rather than only 18-24 year olds. This will provide a better view of the effect outreach has on all tobacco users in Idaho.

Health Priority: OBESITY
Five Year Goal: Reduce the burden of obesity in Idaho
SMART Objective(s): Decrease the percentage of children age 10-17 who are overweight or obese from 27.8% to 26.8% by December 2017

Strategy 1: Increase healthy options for infants and children through awareness, education, and collaboration.				
Measure 1: Number of childcare providers who have participated in Let's Move trainings	Baseline	3 Year Cumulative Target	Actual	Met/Unmet
	110 (SFY2015)	280	172	Unmet
Measure 2: Number of childcare providers that develop an action plan to improve nutrition	Baseline	3 Year Cumulative Target	Actual	Met/Unmet
	80 (SFY2015)	200	130	Unmet
Measure 3: Percentage of children on WIC age 2-5 who are overweight or obese	Baseline	Annual Target	Actual	Met/Unmet
	28.1% (SFY2016)	26%	17%	Unmet
Measure 4: Percentage of women on WIC who are still breastfeeding at 3 months	Baseline	Target	Actual	Met/Unmet
	53.6% (SFY2016)	55%	50.6%	Unmet
Measure 5: Percentage of 3rd grade students who are overweight or obese based on BMI	Baseline	Target	Actual	Met/Unmet
	29.7% (2011-12)	26%	28.6	Unmet

Youth overweight and obesity is defined on pages 39 and 40
 Adult overweight and obesity is defined on pages 41 and 42

Summary of the work completed to date:

Idaho Physical Activity and Nutrition (IPAN) Coordinators implemented 14 Let's Move! Child Care (LMCC) workshops in SFY16. Attendance numbers are decreasing as the provider population with interest in this subject becomes saturated. IPAN staff worked with IdahoSTARS to connect the Professional Development System of trainings to online Better Kid Care (BKC) trainings developed by Penn State Extension, specifically focusing on the five LMCC online modules BKC developed for providers. These trainings are being promoted by IdahoSTARS and IPAN coordinators as professional development opportunities for Idaho's providers. If all five modules are taken, a provider will receive 10 credits at a cost of only \$25.

Moving forward, DPH IPAN staff and partners will develop a shortened version of the LMCC 2-day workshop format to be facilitated as a face-to-face, hands-on supplement to the online trainings. One set of workshops will be implemented by each local public health district in FY17 as they will also begin promoting the online training modules.

The caregivers of all WIC participants who are assigned a nutrition risk code for overweight or obesity are scheduled to meet with a registered dietitian to discuss weight and healthy options going forward. There was some discrepancy in data when the initial targets were created. All pregnant women participating in the WIC Program are made aware of the benefits of breastfeeding and the peer counseling support offered by the clinics. Peer Counselors are assigned postpartum WIC participants and engage in regular follow-up and coaching for breastfeeding success.

Progress Report for 2016 Strategies and Measures

Introduction:

This section is an update on the status of strategies and measures selected for *Get Healthy Idaho: Measuring and Improving Population Health* (July, 2015). The health priorities selected were access to care, diabetes, tobacco, and obesity. Over the past year and a half, work on these strategies crossed multiple bureaus and divisions within the Department of Health and Welfare and involved partnerships from outside of the Department.



Health Priority: ACCESS TO CARE
Five Year Goal: Increase access to healthcare services
SMART Objective: Initiate three efforts to identify or address barriers facing Idaho's underserved areas and populations by December 2016

CY = Calendar Year
 SFY = State Fiscal Year

Strategy 1: Review and renew healthcare shortage areas.				
Measure 1:	Baseline	Target	Actual	Met/Not Met
Number of designated areas qualifying as dental, mental, primary care Health Professional Shortage Areas	0 (CY2015)	70	93	Met
Measure 2:	Baseline	Target	Actual	Met/Not Met
Number of designated areas qualifying as Medically Underserved Areas	0 (CY2015)	54	53	Met
Strategy 2: Develop and implement Community Health Emergency Medical Services (CHEMS) programs.				
Measure 1:	Baseline	Target	Actual	Met/Not Met
Number of Idaho EMS agencies recruited to participate in the CHEMS initiative	2 (CY2015)	3	4	Met
Measure 2:	Baseline	Target	Actual	Met/Not Met
Number of paramedics receiving formal CHEMS trainings	0 (CY2015)	12	9	Not Met
Strategy 3: Recruit new and existing primary care medical homes (PCMH) to participate in the SHIP.				
Measure 1:	Baseline	Target	Actual	Met/Not Met
Number of primary care clinics recruited to participate in the State Healthcare Innovation Plan PCMH transformation	13 (CY2015)	55	55	Met
Measure 2:	Baseline	Target	Actual	Met/Not Met
Number of Regional Health Collaboratives established	0 (CY2015)	7	7	Met

Summary of the work completed to date:

Three types of Health Professional Shortage Areas (HPSA) are measured in Idaho: primary care, dental, and mental health. Medical doctors in a primary care shortage area provide direct patient and outpatient care in one of the following primary care specialties: general or family practice, general internal medicine, pediatrics, obstetrics and gynecology. The bureau uses federal guidelines to establish Idaho's HPSA designations. In 2015, 93 areas in Idaho were designated given a HPSA designation. In 2015, 53 areas qualified as medically underserved areas (MUA). Thirty of Idaho's 44 counties were reviewed during the year, with one being newly designated and two counties moving from partial designation to full designation.

Two local Emergency Medical Services (EMS) agencies have committed to sending students, five in total, to CHEMS training in year one. Recruitment of agencies to participate in the CHEMS program is ongoing. The initiation of a CHEMS training course for agency administrators has had a positive effect on recruitment.

All local Public Health Districts successfully organized and launched a Regional Health Collaborative in their district.

Health Priority: DIABETES

Five Year Goal: Reduce the economic burden of diabetes in Idaho and improve the quality of life for those who have or are at risk for diabetes

SMART Objective: Increase by 10% the availability of educational opportunities for Idahoans to manage modifiable risk factors associated with diabetes or pre-diabetes by July 2016

Strategy 1: Increase the number of CDC-recognized Diabetes Prevention Programs (DPP) and American Diabetes Association (ADA) or American Association of Diabetic Educators (AADE) Diabetes Self-Management Education (DSME) Programs.				
Measure 1:	Baseline	Target	Actual	Met/Not Met
Number of ADA-recognized/AADE-accredited DSME programs	28 (SFY2015)	33	36	Met
Measure 2:	Baseline	Target	Actual	Met/Not Met
Number of CDC-recognized DPPs	3 (SFY2015)	9	13	Met
Strategy 2: Increase referrals to CDC-recognized Diabetes Prevention Programs and ADA/AADE Diabetes Self-Management Education Programs.				
Measure 1:	Baseline	Target	Actual	Met/Not Met
Number of persons with pre-diabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized DPP	89 (SFY2014)	300	138	Not Met
Measure 2:	Baseline	Target	Actual	Met/Not Met
Number of persons with diabetes how have at least one encounter at an ADA/AADE DSME Program	6,534	8,000	8,050	Met

Summary of the work completed to date:

The Idaho Diabetes Program has offered subgrant awards to health systems and ADA recognized/AADE accredited DSME programs to help increase the number of DSME and DPP programs available in Idaho. The increase in access to these programs is the first step to increasing participant enrollment. Although enrollment numbers were not met for strategy 2, measure 1, the Idaho Diabetes Program has developed and is beginning implementation of a social marketing plan for both DSME and DPP to increase awareness and promote attendance to these programs.

Health Priority: TOBACCO
Five Year Goal: Reduce tobacco use in Idaho
SMART Objective: Increase the percentage of Idaho adult smokers that have attempted to quit smoking in the past 12 months from 61.3% to 66.3% by July 2016

Strategy 1: Increase referrals to cessation services.				
Measure 1:	Baseline	Target	Actual	Met/Not Met
Number of women 21-64 years of age referred for QuitLine/QuitNet cessation classes	708 (SFY2014)	825	673	Not Met
Measure 2:	Baseline	Target	Actual	Met/Not Met
Number of 18-24 year olds who registered for QuitLine/QuitNet cessation services (1-call, multi-call, online)	852 (SFY2015)	895	1,173	Met
Strategy 2: Promote the use of nicotine replacement therapy (NRT) for appropriate individuals enrolled in cessation services.				
Measure 1:	Baseline	Target	Actual	Met/Not Met
Number of 18-24 year olds that were shipped 8 weeks of Nicotine Replacement Therapy	281 (SFY2015)	295	801	Met
Measure 2:	Baseline	Target	Actual	Met/Not Met
Proportion of registrants ordering Nicotine Replacement Therapy the Idaho QuitLine/QuitNet	73% (SFY2015)	75%	91%	Met

Summary of the work completed to date:

Project Filter developed and implemented a new campaign this year, taking into account feedback from a focus group on target populations prevalent in Idaho. One of the campaign focuses was designed to reach pregnant mothers in the 18-24 age range. Project Filter has also been working with several universities in an effort to develop or strengthen tobacco policies, having a direct effect on male and female 18-24 year olds. The outcomes resulting from these efforts are increased call volume and NRT orders for the targeted age group.

Overall, 18-24 year olds are not a large proportion of callers to the Idaho QuitLine. Project Filter plans to collect and report on these same measures for next year, but expand reporting for the entire population rather than only 18-24 year olds. This will provide a better view of the effect outreach has on all tobacco users in Idaho.

Health Priority: OBESITY
Five Year Goal: Reduce the burden of obesity in Idaho
SMART Objective(s): Decrease the percentage of children age 10-17 who are overweight or obese from 27.8% to 26.8% by December 2017

Strategy 1: Increase healthy options for infants and children through education and collaboration.				
Measure 1:	Baseline	Target	Actual	Met/Not Met
Number of childcare providers who have attended Let's Move! Child Care trainings	170	280	152	Not Met
Measure 2:	Baseline	Target	Actual	Met/Not Met
Percentage of children on WIC age 2-5 who are obese	7%	6%	11.9%	Not Met
Measure 3:	Baseline	Target	Actual	Met/Not Met
Percentage of children on WIC age 2-5 who are overweight	9%	8%	16.2%	Not Met
Measure 4:	Baseline	Target	Actual	Met/Not Met
Percentage of women on WIC who initiated breastfeeding at birth	86% (SFY2013)	90%	86.7%	Not Met
Measure 5:	Baseline	Target	Actual	Met/Not Met
Percentage of women on WIC who are still breastfeeding at 3 months	52% (SFY2013)	55%	53.6%	Not Met
Strategy 1, Measure 2 and Measure 3: The caregivers of all WIC participants who are assigned a nutrition risk code for overweight or obesity are scheduled to meet with a registered dietitian to discuss weight and healthy options going forward. There was some discrepancy in data when the initial targets were created. Strategy 1, Measure 4 and Measure 5: All pregnant women on WIC are made aware of the benefits of breastfeeding and the peer counseling support offered by the clinics. Peer Counselors are assigned postpartum WIC participants and engage in regular follow-up and coaching for breastfeeding success.				

Youth overweight and obesity is defined on pages 35 and 36
 Adult overweight and obesity is defined on pages 37 and 38

Summary of the work completed to date:

Idaho Physical Activity and Nutrition (IPAN) Coordinators implemented 14 Let's Move! Child Care (LMCC) workshops in SFY16. Attendance numbers are decreasing as the provider population with interest in this subject becomes saturated. IPAN staff worked with IdahoSTARS to connect the Professional Development System of trainings to online Better Kid Care (BKC) trainings developed by Penn State Extension, specifically focusing on the five LMCC online modules BKC developed for providers. These trainings are being promoted by IdahoSTARS and IPAN coordinators as professional development opportunities for Idaho's providers. If all five modules are taken, a provider will receive 10 credits at a cost of only \$25.

Moving forward, IPAN staff and partners will develop a shortened version of the LMCC 2-day workshop format to be facilitated as a face-to-face, hands-on supplement to the online trainings. One set of workshops will be implemented by each local public health district in FY17 as they will also begin promoting the online training modules.

The caregivers of all WIC participants who are assigned a nutrition risk code for overweight or obesity are scheduled to meet with a registered dietitian to discuss weight and healthy options going forward. There was some discrepancy in data when the initial targets were created. All pregnant women participating in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program are made aware of the benefits of breastfeeding and the peer counseling support offered by the clinics. Peer Counselors are assigned postpartum WIC participants and engage in regular follow-up and coaching for breastfeeding success.

Population Health Assessment Summaries

Results are presented below by topic and contain responses categorized by area of the state served (i.e., Statewide vs. Public Health District). Because some of the organizations and agencies who responded to the health assessment survey work across multiple public health district boundaries their contributions to the health assessment are listed at the top of the table under “Statewide.” The following priority health issues were highest among all of the responses (highest priority listed at the top with number of references in 2015 and 2016 combined):

- Obesity (17)
- Diabetes (16)
- Mental Health/Behavioral Health (15)
- Tobacco Use (15)
- Suicide (13)
- Physical Activity (13)
- Nutrition/Food Insecurity (11)
- Cardiovascular Health (11)
- Access to Care/Uninsured (11)
- Substance Abuse (11)

Those responses with an asterisk (*) in the following tables denote those 2016 and 2017 survey responses from organizations or agencies which have not ever conducted a health assessment or have not conducted a health assessment within the previous 5 years.



Community Health Assessment Summaries



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Population Health Assessment Results

What are the priority health issues for your organization or agency? (examples: drug abuse, tobacco use, diabetes, sedentary lifestyle)

Statewide

(2017)

1. Tobacco use, obesity, drug abuse, mental healthcare, workforce.
2. * Increased management of chronic conditions, which includes low back pain, diabetes, heart disease, opioid issues/pain management, as well as driving greater focus on prevention and wellness initiatives with our employer clients and members.
3. * Heart Disease and Stroke, and all contributing factors (tobacco, obesity, nutrition, physical activity, sedentary lifestyle, systems of care, access to health care, etc).

(2016)

1. Oral cancer Screenings; tobacco use; rate of cavities; emergency care and drug abuse.
2. * Heart disease and stroke/cerebrovascular and related contributors including tobacco use; access to care; healthy eating options and marketing; active living (PE, Safe Routes to School, Complete Streets); systems of care (facility capabilities, data registries).
3. * Diabetes; weight management; exercise; nutrition services (including medical nutrition therapy); healthy diet.
4. * Preventing lung disease and supporting those with lung disease: tobacco prevention and cessation; education and resources for those with asthma; COPD; lung cancer; and other lung disease; advocacy for smoke-free air and other air quality issues.
5. * Opioid abuse; mental health and suicide prevention; tobacco prevention; obesity; and diabetes.
6. * Food insecurity.

Public Health District 1

(2017)

1. We are currently in the middle of conducting our CHA and have yet to analyze the results.

(2016)

1. Obesity; diabetes; mental Health; and suicide prevention.

(2015)

Substance abuse; illicit drug use; diabetes; mental health; tobacco use; obesity; suicide; physical inactivity; teen pregnancy and teen birth rate; cancer related mortality; child neglect and abuse.

Public Health District 2

(2017)

N/A - there were no responses from organizations or agencies who serve Public Health District 2 exclusively.

(2016)

1. Overweight/obesity/diabetes; access to health insurance; and behavioral health.
2. * Drug abuse; diabetes; sedentary lifestyle; and obesity.

(2015)

Mental health; suicide; alcohol abuse; drug abuse; affordability of healthcare; access to healthcare; physician shortage; lack of dentists; obesity; overweight; lack of child health and prevention resources; physical activity; nutrition; tobacco use and primary prevention/cessation; teen pregnancy; cancer; diabetes; diabetes care and management; smoking; heart disease and stroke.

Public Health District 3

(2017)

1. Diabetes; behavioral health issues and hypertension.
2. Behavioral health; maternal and infant health; diabetes; oral health; senior health.

(2016)

1. Diabetes; hypertension; obesity; Social determinants of Health
2. Selected measures include: prenatal care, food insecurity, # of support providers (community health workers, CHEMS, peer support, etc.), oral health, obesity, and immunizations Top six in social determinants and health issues are listed below: Food insecurity, uninsured adults, prenatal care, early childhood ed., number of providers, poverty, immunizations, obesity and overweight, tobacco use, unintended pregnancy, diabetes, oral health.

(2015)

Obesity; high cholesterol; diabetes; poor nutrition habits; asthma; tobacco use; sexually transmitted infections (STIs); adult physical inactivity; teen births; high blood pressure; binge drinking; unsafe sex; mental illness; chronic disease; cancer; lung cancer; female breast cancer; prostate cancer; colon cancer; motor vehicle crashes; higher cost of healthy food options; fruit and vegetable consumption; physical inactivity; prenatal care; lack of health insurance coverage; lack of medical home; high cost of oral health; hypertension; cholesterol; mental health; suicide.

Public Health District 4

(2017)

1. Obesity, Mental Illness and substance abuse (we combine them as one need since they are so intertwined); Access; Tobacco Prevention and Cessation (with greater priority to prevention).
2. Obesity; diabetes; mental health/suicide; health insurance.
3. Lack of after-school programming preventing childhood obesity and increases access to nutrition and physical activity; Tobacco use; Lack of mental health resources.

(2016)

1. Obesity and related health issues; Mental health and substance abuse; Access for affordable care; Tobacco use.
2. *Tobacco use; nutrition; physical activity.

(2015)

Alcohol use and abuse; binge drinking; substance abuse; illicit drug use; vehicle crashes; accidents; diabetes; mental health; safe sex education; tobacco use; tobacco prevention; weight management; obesity; wellness/prevention; high cholesterol; skin cancer; suicide physical inactivity; hypertension; nutrition; low fruit and vegetable consumption; asthma; skin cancer; high teen birth rate; sexually transmitted infections; senior services; high percentage of the population reporting fair or poor general health; healthcare access including mental health; lack of health insurance coverage; lack of medical home; lack of healthy safe and nurturing relationships; high cost of oral health; lack of access to health food; lack of prenatal care.

Public Health District 5

(2017)

N/A - there were no responses from organizations or agencies who serve Public Health District 5 exclusively.

(2016)

1. Overweight/Obesity; Cancers Pregnancy Prevention; BH and Suicide.

(2015)

Affordable care; affordable health insurance; availability of behavioral health services; more providers accepting public health insurance; screening programs; chronic disease management (diabetes); screening programs (mammography); chronic disease; access to healthcare for low income populations; access to behavioral health services for low income populations; shortage of specialists; primary care providers; children and family services; education support and assistance programs; homeless services; teen pregnancy/children in poverty; substance abuse services and programs; weight management; wellness/prevention; exercise programs/education; safe-sex education programs; tobacco cessation programs; access to public transportation; physical inactivity; services for aging population; ambulance response times; weekend pharmacy/lack of pharmacy; dental care; exercise programs/education (adult physical activity); nutrition education (teen nutrition); safe-sex education programs (STIs, teen birth rate); substance abuse services and programs; wellness and prevention (breast cancer, high cholesterol, lung cancer, respiratory disease, suicide).

Public Health District 6

(2017)

1. Heart disease; Diabetes; Tobacco Use; Suicide.
2. * Smoking; sedentary lifestyle; obesity; transitions of care; HIV infection.

(2016)

1. Heart disease; diabetes; suicide; Rx Drug abuse.
2. Heart Disease; Diabetes; Suicide.
3. Diabetes; tobacco use; obesity in adults and children; heart disease; suicide.
4. * Diabetes/obesity and substance use.

(2015)

Low-cost services; outreach for patients who do not access preventive care; communication with the community to address negative perceptions; continued emphasis on patient satisfaction; follow-up with patients who have been referred to other providers for care; accident prevention; suicide prevention; increase physical activity levels; increase prenatal care access and education; increase availability of health resources in Spanish; increase preventive screening rates; increase public awareness of existing resources.

Public Health District 7

(2017)

1. * Tobacco use; Substance Abuse; Obesity (child and adult); Food Safety; Lack of affordable health care (including dental health); Behavioral Health, including suicide; Immunization Rates; Increase in STD rates; Low cancer screen rates (colon, breast, etc.); Diabetes; Breastfeeding rates; Food insecurity.

(2016)

1. Child & Adult Immunizations; Tobacco/E-cigarette use by minors; Drug Abuse; behavioral health/Suicide; lack of affordable healthcare; lack of access to services (medical and dental); high poverty rates.

(2015)

Affordability of health services; mental health/suicide; alcohol abuse/substance abuse; palliative care and hospice; accidents; prevention/wellness; compliance behavior; Alzheimer's; cancer; stroke; lack of availability/access to mental health services; affordability of healthcare services; obesity and the need for a prevention/wellness resource center; addiction (alcohol and substance abuse); severe and persistent mentally ill conditions; lack of insurance; sexual assault; cancer services.

Based on the results of your most recent CHA, what (if any) are your most positive population measures (i.e., what is working)? (examples: low obesity rates, low poverty rates, high immunization rates)

Statewide

(2017)

1. * Through our Total Cost of Care program we see improved management of chronic conditions, appropriate use of pharmaceuticals, and increased engagement in preventive care. Additionally, we see some pockets of reduced avoidable ER usage (urgent care as alternative).
2. * Reduced access to tobacco; increased opportunity for physical exercise; improved nutrition options in public places.

(2016)

1. Sealants on kids.
2. * We are working on collecting more data for RDNs. Data collection is scattered. RDNs in hospitals may have data. RDNs in private practice and SHIP clinics are working together to collect data.
3. * Youth tobacco prevention programming is successful.
4. * Decrease in the number of food insecure Idahoans.

Public Health District 1

(2017)

N/A - no response.

(2016)

1. Obesity; diabetes; mental health; suicide prevention.

(2015)

Low crime; good jobs and healthy economy; access to healthcare.

Public Health District 2

(2017)

N/A - no response.

(2016)

1. Overweight/Obesity/Diabetes; access to health insurance; behavioral health.
2. * Our pain prescriptions have decreased as a result of our Controlled Substance Committee's diligent work.

(2015)

Low cancer; heart disease; diabetes; and flu/pneumonia mortality rates; moderately good environmental quality driven by low air pollution; low crime; good jobs and healthy economy; access to healthcare.

Public Health District 3

(2017)

1. Lower whooping cough rates.
2. Dental sealants for high risk children; Weight assessment and counseling for children and adolescents.

(2016)

1. High hypertension control.
2. Adults getting annual A1C; alcohol use in teens; binge drinking rates; heavy drinking rates.

(2015)

Years of Potential Life Lost (YPLL) is significantly lower than the national average; Low birth weight is below the national average; Supplemental Nutrition Assistance Program (SNAP); cash public assistance; active health resource guide; Preschool through college (P-16) coalition; suicide prevention efforts; Treasure Valley Education Partnership (TVEP); Bank On Treasure Valley; 2-1-1 Idaho Careline.

Public Health District 4

(2017)

1. Valley County is in the top ten percent nationally (based on Robert Wood Johnson County Health Rankings) in 1) length of life, 2) smoking rates, 3) number of physicians per population, 4) preventable hospital stays, 5) obesity rates; interesting to note that Valley County Idaho is #1 nationally out of 3,100 counties for length of life in 2017; we were second nationally in 2016: again based on RWJF.
2. Health-focused agencies have the most policy, systems, and environmental supports; One school district had strong policy and environmental supports for nutrition and physical activity.

(2016)

1. Longevity; aggregate positive health behaviors; high number of local primary care providers.

(2015)

Availability of outdoor recreation; access to healthy foods; good air quality; low levels of violence and abuse; veterans services; prenatal care programs; community exercise programs; Years of Potential Life Lost lower than national average; low level of low birth weight; SNAP; CASH public assistance; P-16 Project; suicide prevention efforts; Treasure Valley Education Partnership; Bank On Treasure Valley; 211; emergency food assistance; clinics with sliding fee scales; emergency shelter; legal assistance; transportation assistance; crisis child care; elder care assistance; long term comprehensive care for people with disabilities.

Public Health District 5

(2017)

N/A - no response.

(2016)

1. Immunizations; Evidenced Based HV with Early Headstart; Health Promotions for PAN; partnership with health systems.

(2015)

In Gooding county: Low birthweight percentages are lower low smoking rates; low rates of excessive drinking; low percentage of low birth-weight babies; low breast cancer death rates; low melanoma death rates; low rates of poor physical and mental health days experienced; low asthma rates; low diabetes rates; low cancer death rates; low skin cancer death rates; low heart disease death rates; low respiratory disease death rates; low Alzheimer's death rates; low diabetes death rates; low rates of obesity; low rates of Sexually Transmitted Infections; low overweight/obesity rates; high rates of mammography screening; low rate of children living in poverty; high rate of access to recreational facilities. Other counties in the region experience: slightly higher rate of cancer deaths; high rate of lung cancer deaths; high rate of breast cancer deaths; high rate of prostate cancer deaths; high rate of respiratory disease rates; high rate of accident deaths; high rate of cerebrovascular deaths; high rate of Alzheimer's deaths; high rate of diabetes deaths; high suicide death rates; high rates of physical inactivity; high vehicle crash death rates; high teen birth rate; high rates of preventable hospital stays; low cancer screening rates.

Public Health District 6

(2017)

1. Healthy People 2020 goals met in the following areas: Death rate due to cancer, Death rate due to breast cancer, Death rate due to lung/bronchus cancer, Death rate due to prostate cancer, Adult obesity, Mothers who breastfeed, WIC participation is higher (42.7%) than the statewide average (32.5%).
2. Increasing physical activity; limiting access to prescription opiates; screening for HIV and providing access to HAART.

(2016)

1. Low HIV rates.
2. Adequate prenatal care; Power County low cancer rates; Franklin County COPD low rates; mothers who breastfeed.
3. * Just got a new seat belt and child safety seat use ordinance for the reservation.

(2015)

Slightly lower rates of asthma; lower binge drinking rates; slightly lower illicit drug use rates; higher rates of prostate screening; slightly lower rate of no dental visits. Low rates of binge drinking.

Public Health District 7

(2017)

1. * Partnerships with cities, communities, and businesses to increase healthy lifestyles. Increased breastfeeding rates. School-based immunization clinics; increasing adolescent immunization rates. Reduced foodborne outbreaks. Lower senior fall rates.

(2016)

1. Immunizations; Low teen birth rates; low tobacco use rates among adults and pregnant women; low HIV rates; adequate prenatal care; good breastfeeding rate; availability of crisis center in the region.

(2015)

In general, residents of Teton County are healthier than most of Idaho. Premature death rates are lower; obesity rates are lower; teen birth rates are lower; smoking; physical inactivity; and Sexually Transmitted; Infection values are lower; education metrics better than average in Idaho; mammography screening.

Based on the results of your most recent CHA, were there any populations, sub groups, or geographic areas prioritized? (examples: Hispanics, kids age <5, Clark County)

Statewide

(2017)

1. Low income, minority.

(2016)

1. Children, especially 0-5, and the aging adult.
2. * Not currently, but partial focus of Safe Routes to School efforts on rural/ low income areas.
3. * Youth in rural areas.
4. * We recently introduced a senior food box program to better serve that population. We also have programs specific for children. We also utilize data showing food insecurity on the state and county level to help us target the needs of the area.

Public Health District 1

(2017)

1. Mental health with the males.

(2016)

1. Adults with diabetes; areas with limited access to care; specifically mental health services.

(2015)

Adults who are obese and/or have diabetes; pregnant teens.

Public Health District 2

(2017)

N/A - no response.

(2016)

1. Behavioral health population.
2. * Native Americans.

(2015)

Adult persons who are obese and/or have diabetes; pregnant teens.

Public Health District 3

(2017)

1. Homeless; children and adults; and migrant and seasonal farmworkers.
2. Hispanic communities; frontier communities; the uninsured.

(2016)

1. Hispanics; migrant and seasonal farm workers; homeless.

(2015)

Overweight/obese adults; those who have not graduated high school; unemployed; low income households; males 18-34 years; persons who do not engage in regular physical activity; tobacco users.

Public Health District 4

(2017)

1. Our CHNA data is stratified on 5 tiers of economic and 5 tiers of education levels.
2. Low income.
3. The health assessment surveyed Elmore County and five distinct sectors. Those sectors included schools, healthcare, businesses, community institutions, and county-level government.

(2016)

1. Low income; low education.
2. * Rural communities; refugees; child care providers.

(2015)

Young children; ages 18-64; income < \$35,000; no high school diploma; adults; low income; individuals without a high school diploma; children in poverty.

Public Health District 5

(2017)

N/A - No response.

(2016)

1. Hispanic youth and childhood obesity primarily in Minidoka and Jerome Counties. Teen pregnancy rates in Twin Falls, Jerome.

(2015)

Uninsured; People with income level less than \$15,000; Hispanics; Gooding County.; People with income level less than \$35,000; Those with lower educational attainment (especially no high school diploma); Males 18-34.

Public Health District 6

(2017)

1. Oneida County: Ratio of primary care physicians to people is 1:4169 as compared to Bannock County at 1 primary care provider per 726 people. Access to care is a critical issue. The percentage of mothers who reported Medicaid as a payment source for prenatal care and/or delivery is significantly higher in PHD6 (52.7%) than statewide prevalence at 43.0% according to PRATS, 2015. Suicide risk among LGBTQ youth and adults.

2. * PLWH; aging adults.

(2016)

1. School based physical education; suicide prevention among faith-based organizations and LGBT community; access to healthy food options; low cost of unhealthy foods/drinks.

2. * American Indian.

(2015)

None were identified.

Public Health District 7

(2017)

1. * Children; Hispanics; Senior population; MSM; More Rural Counties in our district (Clark, Custer, Lemhi, Teton).

(2016)

Immunizations – children and adults; Hispanics; pregnant women; access to care in Clark County; people in poverty.

(2015)

Uninsured persons; low-income persons; and minority groups. Other 'vulnerable' populations included people who have no high school diploma; are unemployed; are severely work disabled; have major depression; or are recent drug users.

Please list specific factors your organization or agency identified in your CHA that contribute to greater health risks and poorer health outcomes for your patient population. (examples: availability of junk food, lack of school physical education programs, social determinants, high poverty rate, high obesity rates)

Statewide

(2017)

1. Obesity rates; drug abuse; access to care; social determinants of health.
2. * Lack of patient accountability in both wellness and management of chronic diseases. Employers, our physicians, and our health plan have a myriad of incentives to encourage members to alter lifestyle choices and behaviors, but patient engagement/accountability remains an issue.
3. Social determinants of health; lack of access to nutritious foods; lack of opportunity for physical activity; lack of health insurance coverage; rural populations.

(2016)

1. Social determinants; high poverty; drug tobacco and alcohol use; availability of junk food and soda.
2. * Lack of physical education in school; lack of physical activity throughout the day; community walk and bike ability; access to healthcare; availability of nutritious food versus junk food.
3. * Obesity and diabetes rates; weight and BMI; poor diets (intake of fruits and vegetables, esp.).
4. * Social determinants.
5. * Social determinants of health.
6. * Inconsistent availability of nutritious food; lack of health insurance preventing people from monitoring or managing their health.

Public Health District 1

(2017)

1. Lack of access due to our rural setting and lack of mental health care providers.

(2016)

1. Barriers to accessing care; lack of mental health resources; transportation and health education.

(2015)

Long distances for health services; rural areas lack sidewalks; fitness centers/recreational areas.

Public Health District 2

(2017)

N/A - no response.

(2016)

1. High poverty rate; high suicide rate; high obesity.
2. * High poverty rates with reduced access to healthy foods. High obesity rates and a lack of nutritional knowledge.

(2015)

Heavy alcohol consumption and high access to liquor stores; above average population living in poverty; lower life expectancy; high tobacco use; low cancer screening rates; low socioeconomic status; poor nutrition and lack of physical activity; low quality of clinical care; high preventable hospital stay rates; long distances to health services; rural areas lack sidewalks; lack of fitness centers/recreational areas.

Public Health District 3

(2017)

1. Lack of availability of nutritious food; high poverty rate; lower than average education level; high level of issues with health literacy; lack of transportation and lack of health insurance.
2. High poverty rates; high obesity rates; stigma around behavioral health; adverse childhood experiences; food deserts; low access to providers.

(2016)

1. Food deserts; lack of providers; poverty; ALICE population; lack of early childhood ed.; poor transportation
2. Poverty; lack of health insurance; cultural norms.

(2015)

Low rates of cervical and colorectal cancer screenings; low rates of mammography screenings; low college graduation rates; poor access to primary care and oral healthcare. High rates of unemployment; poverty/children living in poverty; percentage of single parent households; uninsured; aging population; unbanked and under-banked families; hypertension; high cholesterol rates. Prenatal care; access to healthcare services; mental health services; health insurance coverage medical home; physical activity; preventative medical and dental services; public transportation; access to healthy food options; poor nutritional habits; inadequate social support; high cost of dental health; a decrease in median household income.

Public Health District 4

(2017)

1. A. While our obesity rates are good compared to U.S. averages, they pose a gigantic health hazard. B. Prevalence of Mental illness and dearth of psychiatric providers. C. Impact of poverty. D. Lack of access and lack of health insurance. E. Excess alcohol consumption Not identified in our CHNA but know health issues include 1. Disengaged youth (youth who don't have relationships at school, in the community, and poor family dynamics). 2. Domestic violence and sexual abuse 3. A learned pattern of thinking that increases depression and anxiety.
2. Low income; poor diet; lack of exercise; isolation.
3. Unsafe and inconsistent built environment; Lack of after-school programming; Lack of physical activities in school programming; Lack of mental health resources; Stigma around mental health; Isolation among senior population; Lack of worksite wellness programs and initiatives in community institutions and businesses; Social determinants/high ALICE population.

(2016)

1. Obesity, although slightly lower than state average; high alcohol consumption; lack of access to psychiatric providers.
2. * Social determinants; high obesity rates; high tobacco rates (including e-cig use in youth); high poverty rates; lack of access to healthcare.

(2015)

Lack of: education support; prenatal care; physical activity; public transportation; providers accepting public insurance; screening programs; social support.

High percentage/rate of: hypertension; high cholesterol; suicide; children in poverty; preventable hospital stays; uninsured adults; poor mental health days; people living in poverty; unbanked and under banked families; mammography screening; high level of access to fast food. Decrease in median household income (with inflation adjustment lower than it was in 1980).

Public Health District 5

(2017)

N/A - No response.

(2016)

1. Access to healthy foods; demographic cultural norms; adequate access to parks; walking trails; exercise opportunities; access to mammography screening (no or under insured) as a result of transportation; continued use of cigarettes from youth (age in new consumers and age out of cessation participants).
2. Access to BH services for no or under insured individuals.

(2015)

Health indicators: Overweight/Obesity; high blood cholesterol; diabetes; fruit and vegetable consumption; low engagement in physical activity in both adults and teens; low colon cancer screening; high teen birth rates; high percentage of children living in poverty; high rates uninsured; high obesity rates; high rate of poor mental health days; high rates of preventable hospital stays; low access to primary care physicians; alcohol use; smoking.

Clinical Care: availability of primary care providers; chronic disease management; immunization programs; improved healthcare quality; integrated coordinated care; prenatal care programs; screening programs Social and Economic Needs: children and family services; disabled services; homeless services; job training services; senior services; veteran's services; violence and abuse services; Low health literacy.

Physical Environment: availability of recreation and exercise facilities; healthier air quality; water quality, etc. High alcohol and illicit drug use; high vehicle crash death rates; higher rates of overweight (but not obesity); mental illness; teen exercise; sexually transmitted infections; teen birth rate; smoking; accidents; breast cancer; cerebrovascular diseases; suicide. High alcohol and illicit drug use; high vehicle crash death rates; higher rates of overweight (but not obesity); mental illness; teen exercise; sexually transmitted infections; teen birth rate.

Public Health District 6

(2017)

1. Not having a regular source of care (primary care provider); Teenage alcohol use in PHD6 was 25%; Percentage of adults in PHD6 who engage in physical activity 150 minutes per week is 24.5%.
2. * lack of access to primary care; poverty; substance abuse; fragmented health information systems.

(2016)

1. High poverty rate; limited access to primary and specialty care; limited opportunities for active transportation and regular physical activity; food insecurity; limited access to preventive behavioral health services; easy access to firearms
2. Lack of health insurance and poverty; low rates of physical activity among school aged children; access to firearms; lack of access for behavioral health
3. * High diabetes; obesity rates; and substance use rates

(2015)

Lack of preventative care; limited financial resources within the community; delaying treatment until a problem has become severe; alcohol; drug; and tobacco use. Lowest life expectancy in state; high unemployment rate; physician shortage; low vegetable consumption; high levels of inactivity

Public Health District 7

(2017)

1. * Poverty rates; Lack of insurance; Rural areas; Transportation; Lack of walkable communities, especially in rural counties; Lower level of education; Access to inaccurate health information; Adverse childhood experiences (ACEs).

(2016)

High poverty rates; low education levels; lack of health insurance; lack of behavioral health resources for uninsured; built environment (lack of safe walking/biking paths); poor diets.

(2015)

Conclusions based on observations from Teton County compared to all other Idaho counties, in terms of health needs: low birth-weight births; excessive drinking; motor vehicle crash death rates; percentage of uninsured is very high; infant mortality; suicide; coronary heart disease rates; stroke rates.

Based on the results of your most recent CHA, please list the gaps in services, community resources, funding, etc., which your organization or agency have identified. (examples: no funding to support diabetes education, no local data on adolescents, etc.)

Statewide

(2017)

1. Lack of mental health care providers; tobacco/drug prevention/education.
2. * Lack of communication across the state; lack of disease specific funding; population specific data.

(2016)

1. Limited rural access to dental care; low-reimbursement by Medicaid; coverage gap for Medicaid in adults and seniors; lack access to data on hospital ED admissions/re-admissions for dental disease.
2. * Local level specific data (county).
3. * Diabetes education; wellness assessments; reimbursement through state Medicaid is very low. Variability in coverage for nutrition services by Idaho's major insurance companies. For example, some state employee plans do not cover nutrition services. Lack of data (weight, diabetes management, hypertension, etc.).
4. * Stigma attached to those with lung disease reduces awareness of need; hard to reach rural populations with programs and services.
5. * Access to care.
6. * Funding to support more collaborative efforts between healthcare providers and hunger relief organizations; funding to increase capacity for hunger relief.

Public Health District 1

(2017)

1. Lack of mental health care providers.

(2016)

1. Limited mental health providers; limited diabetes treatment programs; lack of diabetes prevention programs.

(2015)

Physician and dental shortage areas; decreased funding in teen pregnancy prevention.

Public Health District 2

(2017)

N/A - no response

(2016)

1. Lack of providers overall, especially mental health providers. Lack of access to exercise opportunities in rural/frontier counties.
2. * We actually have great access to grants. It's difficult at times getting it dispersed to the masses.

(2015)

No palliative care; physician and dental shortage areas; decreased funding in teen pregnancy prevention.

Public Health District 3

(2017)

1. Lack of mental health services in our rural communities; No funding for CRC screening costs; Uninsured rate; inadequate funding for mammograms.
2. Large uninsured population; little incentive for affordable housing and affordable/healthy food; lack of transportation; coordination between members in the MHN.

(2016)

1. Little local mental health data; no crisis center; large uninsured and underinsured population; lack of affordable and healthy foods; lack of transportation resources for healthcare; funding for school-based services.
2. Funding for health insurance; lack of behavioral health services in rural areas; lack of specialty providers willing to see uninsured patients.

(2015)

Lack of the following: weight management programs; nutrition education; substance abuse services and programs; sex education; wellness prevention programs; education and access to preventive services; affordable health insurance; chronic disease management programs; mental health services; prenatal care; post-secondary education; community hubs; in-home service; central one-stop shop; communication of community resources; lack of public transportation; and basic lack of knowledge of available resources; education levels.

Public Health District 4

(2017)

1. Dental services for Medicaid; affordable behavior counseling; transportation to medical services; lack of funding to get low income; highly unhealthy people into lifestyle behavior modification programs.
2. Too many to list.
3. Mental Health services that are culturally-competent and accessible; No sustainable funding for afterschool programs across the county; Hispanic population needs the most services but less access due to scheduling conflicts, awareness, and language barriers; No youth-centered community institutions such as Boys & Girls Club, YMCA; Community engagement is lacking and funding streams are limited.

(2016)

1. Access for uninsured
2. * Community partners often don't know all of the resources that exist for patients. No local-level data on priority issues (only available at county level).

(2015)

Lack of access to: Mental health providers; affordable health insurance; job training services; nutrition education; affordable healthcare; behavioral health services; primary care provider; children and family services; healthy foods; healthcare services; mental health; health insurance coverage; affordable dental services; medical home; transportation to and from appointments; chronic disease management; Medicaid dentists; immunization education and low cost options; funding for transportation to Boise for specialty services; prenatal care 1st trimester; wellness and prevention programs; mammography screening.

Lack of: job training services; safe sex programs; Community hubs; In-Home Service; Central One- Stop Shop; recreational facilities; ability to advertise and increase community participation in education and physical activity programs; communication of community resources; public transportation; basic knowledge (i.e. available resources, education levels); nutrition education; substance abuse services and programs; tobacco prevention programs; publicizing current opportunities; creative wellness programs for young ages; consulting access for safety-net providers.

Public Health District 5

(2017)

(2016)

1. It's not so much gaps as it is to coordinate and align community partners toward common goals. Many organizations cross over each other in service delivery without coordinating.

(2015)

Lack of funding for proper worksite wellness programs; there aren't enough providers in the community; no suicide hotline and staff aren't trained to address mental health problems; funding for a program that seemed to successfully help people stay on medications was dropped due to cuts in funding. No public transportation.

Public Health District 6

(2017)

1. Limited/no funding for suicide prevention. Need for additional behavioral health resources/regional crisis center. Lack of a functional Idaho Health Data exchange and inability of EMRs to interact with IDHE. (Regional data measurement not feasible at this time.) Improve access to physical activity opportunities. Need for improved school-based physical activity standards. Availability of affordable, nutrient dense foods. Need for discipline-specific suicide prevention education and public suicide prevention education.

2. * Access to primary care; access to exercise programs / facilities; access to behavioral health and substance abuse treatment programs.

(2016)

1. Limited funding to address heart disease; diabetes; suicide; and Rx drug abuse; extremely limited number of behavioral health providers; limited resources for care coordination.

2. Suicide prevention programs; diabetes programs; walkable cities; bike routes; affordable physical activity options; nutrition education.

3. Lack of behavioral health specialists; need for increased minimum standards for PE in schools in Idaho; lack of walking/recreational trails to support physical activity; need for suicide prevention training/education for gun shop owners/retailers.

4. *Funding.

(2015)

Mental health resources; resources for low-income families; affordable medications; home healthcare; psychiatric care across the lifespan.

Public Health District 7

(2017)

1. * No funding for some health education (food safety) No funding for colon cancer screenings or hepatitis C referrals. Limited medical and dental coverage and provider accessibility for seniors. Lack of affordable healthcare providers in the region (only 2 FQHCs, local public health). Lack of behavioral health services; substance abuse recovery services. Lack of affordable housing for families; lack of transitional housing. Lack of funding for some health education topics (food safety, for example).

(2016)

Lack of access to medical and dental care for uninsured; limited behavioral health providers/resources; lack of access to exercise opportunities in rural communities; transportation-especially in rural counties.

(2015)

The Teton Valley Healthcare CHA provided. Access full assessment here:

http://issuu.com/tvhealthcare/docs/tvhc_chna_complete

Based on the results of your most recent CHA, please list any assets and resources your health clinic or agency have identified that address health issues. (examples: state parks, bike paths, state cardiovascular program, local support for tobacco cessation)

Statewide

(2017)

1. Free clinics; community health centers.
2. * Our community physicians are our best local resource. Collaborating with them through data sharing around cost and quality is our most effective asset.
3. * State CVD and Stroke programs, project filter, HEAL network.

(2016)

1. Dental home assignment for children under 5 enrolled in IdahoSmiles Plan (Medicaid)
2. * Bike lanes and walking paths; state heart disease and stroke prevention program; tobacco cessation support programs; healthy vending in public buildings.
3. * State diabetes and cardiovascular programs; Idaho HEAL.
4. * General support for tobacco prevention; DHW programs and resources; various coalitions.
5. * Increase the Department of Labor workforce recruitment and State loan repayment and forgiveness programs.
6. * Local clinics partnering with local food pantries.

Public Health District 1

(2017)

1. Bike Paths, Boundary Community Hospital; University of Idaho Extension Office; Kootenai National Wildlife Refuge; Elk Mountain Farms; Boulder City Ghost Town; Kootenai Tribal Sturgeon Hatchery; Naples General Store/American Youth Hostel; Law Enforcement/Volunteer Fire/EMS; Outdoor Recreation; Spiritual Health; Local Media; Libraries; Safe place for kids; Community Activities; Farmer's Market; Fishing/Hunting; Parks/Reservoirs; Historic Sites/Museums; Arts/Theatre; Agriculture.

(2016)

1. Community gardens; WIC programs; outdoor recreation (trails and bike paths); higher education; libraries.

(2015)

Many resources are listed for each county which include hospital/clinic locations 'things to do and see,' but they are not tied to health issues.

Public Health District 2

(2017)

N/A - no response.

(2016)

1. A community that cares; SRCC; ACE's training; Partnerships; Communication network.
2. * We have a grant that helps with tobacco cessation. We have two grants for diabetes.

(2015)

Twenty-four (24) pages of local resources provided to address each prioritized issue; the majority are hospital/clinic facilities and local community-based organizations. Fifteen page (15) resource compendium provided in appendix was created as resource to address identified health priorities. Many resources are listed for each county which include hospital/clinic locations, 'things to do and see,' but they are not tied to health issues. Each county page has extensive list of some hospital/clinic resources along with list of 'things to do and places to see,' but not tied to health issues. Additional resources noted include: Public Health Department; Federally Qualified Health Centers; Community Clinics; Veterans Administration; HIS.

Public Health District 3

(2017)

1. We are a fully integrated care system providing medical, dental and behavioral health services in most of our clinics. The communities we serve typically have several parks that are accessible to local residents, our communities also have fairly good access to public health district services.
2. Provider education programs (opioid, cancer, diabetes); care coordination directory; tobacco cessation; WIC; family planning; behavioral health board; Women's Health Check; community advisory councils (in progress).

(2016)

1. Health promotion programs; SHIP; multiple points of contact with people (EH, FHS, NHP, etc); local presence.
2. We have some funding for uninsured patients We are moving to an integrated, one-stop-shop clinic model - medical/behavioral health/dental.

(2015)

Abuse/violence advocacy & services; after school programs / youth mentoring; at-risk youth services; behavioral health and substance abuse services; childcare; chiropractic services; dental services; disability services; educational services; government contacts; homeless services; housing services; hospice services; hospitals; legal services; low income medical resources; nursing homes; public health resources and referral and miscellaneous; services; refugee services; senior services; veteran services; Gem County Health Connection; Gem Economic Development Assoc.; 1, 3, and 5 year action plan of activities and a sustainability plan through IPAN; utilize the Change Tool to support and implement programs and policies; full time advanced EMS; No Sun For Baby class; Look Good Feel Better; Smart 911 education; tobacco cessation; community sharps collection; car seat distribution; CPR class; mammogram promotions; prescription medication drop-off; School Improvement Management Systems training; colon cancer awareness; prenatal classes; Walter Knox Memorial Hospital Health and Safety In The Sun.

Public Health District 4

(2017)

1. Valley County is the healthiest county in Idaho and it's fair to say we have cultivated a culture of health with many assets and organizations working together to create this culture. We have a remarkable bike and pedestrian trail system, miles of Nordic skiing, the amazing Ponderosa State Park, our Chamber of Commerce's mission statement includes providing for community wellbeing. We have a devoted non-profit sector working together to strengthen outcomes and resources. We could write pages about our resources and assets, and our determination to make the social and physical environment more health conducive.
2. Too many to list.
3. Local FQHC, hospital, public health, and other health organizations; One of the school districts.

(2016)

1. Access to natural environment. Excellence state and local parks. A city and county government that believe in and promote health. A county wide coalition that promotes health.
2. * Free tobacco cessation classes. Focus on sustainable environmental and policy changes. SHIP project and creation of the Central Health Collaborative. Focus on the medical-health neighborhood. Academic detailing for pre-diabetes, diabetes, and hypertension.

(2015)

Adequate senior services; high level of flu and pneumonia immunizations; Boise State University; branch location for other universities; outdoor activities; colleges Northwest Nazarene University; College of Western Idaho; Hispanic Cultural Center; education and exercise opportunities but people are not aware. YMCA; Boise VA Medical Center; safety-net clinics; sliding fee scale providers.

Public Health District 5

(2017)

N/A - No response.

(2016)

1. Health in All Policies; MF for tobacco cessation; Board of Health funding for counties not covered by the MIECHV sub-grant for Home Visits and early intervention; expansion of success with Let's Move initiatives.

(2015)

1. Implement Intermountain's diabetes education/lifestyle coaching program to help improve the health of people identified as at-risk for diabetes referred by Family Health Services Clinic; provide additional community education and diabetes education events to help promote awareness of diabetes in the Cassia community. There is a large list of resources available in the North Canyon CHA ... too many to list here and it is not obvious to me which should be included here and which should be left out. See North Canyon CHA for the list if needed.
2. Intermountain provided \$7.6 million in charity care for low-income mental health patients (defined as Medicaid/uninsured with mental disorders and / or substance abuse issues) in more than 2,700 cases in 2012;
3. Collaborative partnerships exist in all urban communities to link uninsured people with community-based behavioral health providers;
4. Intermountain provides grants to Community Health Centers and safety net clinics of \$2.3 million annually for comprehensive health services inclusive of mental health. A list of resources is identified beginning on page 135 of the health needs assessment. A list of resources is identified beginning on page 133 of the health needs assessment.

Public Health District 6

(2017)

1. Portneuf Greenway Outdoor recreational opportunities (biking, skiing, hiking, hunting, etc.); Community Fun Run Series; City parks, state parks and monuments; Suicide Prevention Action Network and other non-profit, health enhancing programs; Problem-solving courts (Mental Health Court, Substance Abuse Court, etc.); Issue-specific support groups (AA, bereavement support groups, Mended Hearts, etc.); Community gardens; Public Libraries.
2. * Federal grant funding: Ryan White III, HRSA / Title 7, Health professions education programs.

(2016)

1. Building walkable/bikeable infrastructure; especially in rural areas; food banks; WIC.
2. Heart disease and diabetes program. Physical activity and nutrition program. Relationships with community partners.
3. Tobacco use prevention and cessation; immunization clinics; excellent community partnerships; Women's Health Check; Parents as Teachers Program; WIC; family planning; emergency preparedness; licensed child care facility inspections; environmental health services; dental fluoride and sealants; cancer prevention and screening; worksite wellness support; Fit and Fall Proof.

(2015)

Very few specific resources were identified except Bingham Memorial Hospital; chiropractors; naturopaths; nursing homes; free clinic; and specialists such as ENTs and orthopedics.

Public Health District 7

(2017)

1. * Local support for tobacco cessation. Patient assistance programs for immunizations. Partnership with community groups who provide funding for healthcare services (mammogram, HIV services, fall prevention, immunizations, children's oral health).

(2016)

Behavioral Health Crisis Center in the community; free tobacco cessation classes; WIC program; immunization clinics (some free ones to support under- and uninsured individuals); Parents as Teach Program; community partnerships/coalitions; fluoride varnish and sealant services for children; Risk Reduction programs for youth; Fit & Fall Proof program; creation of the regional health collaborative through the SHIP program; community health resource directory.

(2015)

There were many resources listed beginning on page 29 of the CHA. Access full assessment here:

http://issuu.com/tvhealthcare/docs/tvhc_chna_complete

What data were used to develop your latest CHA? (examples: education data, Behavioral Risk Factor Surveillance System (BRFSS), Census, county health rankings, health needs survey, focus groups)

Statewide

(2017)

1. * We have several predictive analytic tools which identify both medium to high risk profiles (likelihood of ER or inpatient visit within the next 6 months), but all data is based on what physicians and hospitals identify and code/bill which is submitted to us. We use a risk-adjustment software (Verisk) to assist us in identifying risk factors.
2. * National data resources, BRFSS, county health rankings.

(2016)

1. Smile Survey; BRFSS; census
2. * BRFSS; YRBS; County health rankings; population health data; community commons assessment; national impact data; health needs data; all available data sources
3. * Not applicable to our organization as a whole. Applicable to individual RDNs depending on where they are employed. District health departments (WIC) use data; State WIC; State Child Nutrition Programs; University of Idaho Extension - Eat Smart Idaho (formerly SNAP-Ed).
4. * Population health needs surveys from area health systems; BRFSS; YRBS; ATS; census; focus groups; CDC data; etc.
5. * Educational data.

Public Health District 1

(2017)

1. BRFSS; County Health rankings; survey.

(2016)

1. BRFSS; County Health Rankings; Vital Statistics; IDOL Idaho Primary Care Physicians Workforce Overview; 2013 Idaho Dentists and Dental Specialists Workforce Supply and Demand Summary; Network of Care; Idaho; SPAN Idaho October 2012 Suicide Fact Sheet; US Census.

(2015)

County Health Rankings; National Vital Statistics System-Mortality (NVSS-M); U.S. Census; Advisory group from PHDs 1 & 2.

Public Health District 2

(2017)

N/A - no response

(2016)

1. BRFSS; Vital Stats (ID and WA); CHR; PH-INCD CHA; focus groups; National Information Center for Higher Education; US Census Bureau; The State of Preschool; United Way ALICE report; Community Action Partnership.
2. * Surveys; education data; our medical software (RPMS/EHR).

(2015)

County Health Rankings; communityhealth.hhs.gov; Truven Market Planner; getpalliativecare.org; caringinfo.org; healthmetricsandevaluation.org; UWPHI county Health Rankings; BRFSS; NVSS-M; U.S. Census; population health needs survey; focus groups.

Public Health District 3

(2017)

1. Data is gathered utilizing Community Commons, policy mapper, and UDS mapper. Each of these is a compilation of several data sources.
2. BRFSS; census; focus groups; survey; school data; crime data; vital stats; CDC; Kids Count; IRIS; American Community Survey.

(2016)

1. American Diabetes Association; KIDS COUNT Data Center; BRFSS; National Environmental Public Health Tracking Network; County Health Rankings and Roadmaps; Map the meal gap; Idaho 3rd grade body mass index (BMI) assessment; Population receiving food stamps; Idaho reportable disease summary; Idaho HIV-AIDS and STD statistics; Get healthy Idaho: Measuring and improving population health; Vital Statistics; Pregnancy Risk Assessment Tracking System (PRATS); Idaho's Immunization Reminder Information System (IRIS); Idaho School report card; Idaho Youth Risk Behavior Survey - A healthy look at Idaho youth; Crime in Idaho database; National Center for Education Statistics; National Survey of Drug Use and Health; ALICE: Asset limited, income constrained, employed; American Community Survey; U.S. Census Bureau; U.S. Department of Agriculture; Food Access Research Atlas.

(2015)

BRFSS; IDHW Vital statistics; Community Health Needs Rankings; Key informant interviews with local organizations and leaders; University of Wisconsin Population Health Institute; www.census.gov; County Health Rankings; Outdoor activities; colleges/universities: Northwest Nazarene University; College of Western Idaho; Boise State University; Hispanic Cultural Center; United Way; University of Wisconsin Population Health Institute; Robert Wood Johnson Foundation.

Local school district data.

Public Health District 4

(2017)

1. We collect vital statistics from a number of sources and compile it with qualitative data from interviewing 28 local community health experts.
2. BRFSS, Vital Statistics, CDC, Alzheimer's Assoc, Arthritis foundation, Bureau of Labor Statistics, Comprehensive Cancer Alliance, County Health Rankings, America's Health Rankings, EPA, U.S. Census Bureau, too many to list.
3. The assessment used qualitative and quantitative data through interviews using the CDC CHANGE Tool.

(2016)

1. Interviews with 20+ local health experts. The St. Luke's methodology and resources spent compiling CHNAs has been described as the gold standard by national authorities on CHNA.
2. * BRFSS. YRBS. Census data. County Health Rankings. CHNAs prepared by local hospitals. ALICE Report from the United Way.

(2015)

County Health Rankings; United Way; Saint Al's; expert interviews; University of Wisconsin Population Health Institute; Youth Risk Behavior Surveillance; affected population surveys; Idaho Economics; the Robert Wood Johnson Foundation; Local school district data; County

Health Rankings; United Way; Saint Al's; expert interviews; University of Wisconsin Population Health Institute; Youth Risk Behavior Surveillance; Affected population surveys; Idaho Economics; exercise facilities

Public Health District 5

(2017)

(2016)

1. BRFSS; CHR; local surveys; Network of Care data; YRBSS; PRATS; HP 2020; SLHS (Magic Valley, Jerome, WR) CHNA; SPAN; CDR of Idaho; Intermountain Health System (Cassia); CDC; Vital Stats.

(2015)

BRFSS (Idaho and Utah); Focus group data (primary data); US Census Data (ESRI, 2012 source); County Health Rankings; Idaho Vital Statistics; Affected population surveys and focus groups; In-depth interviews with community leaders

Public Health District 6

(2017)

1. County Health Rankings; Census; BRFSS; Gateway to Health; PRATS; State of Idaho Vital Statistics; Network of Care; IDHW; Years Per Life Lost (YPLL); HP2020; Emergency Department Reports.

2. * Health department data; clinical performance measures; grant program data.

(2016)

1. Vital Stats; BRFSS; County Health Rankings; focus groups

2. BRFSS; County Health Rankings; YRBSS

3. Regional hospital data; County Health Rankings; US Census; Network of Care; Idaho Vital Statistics; BRFSS;

4. *BRFSS

(2015)

Idaho BRFSS; Idaho Vital Records; One-on-one interviews and focus groups with healthcare providers and administrators; Interviews and focus groups with community stakeholders; Census; Vital Statistics Bureau, DHW; Network of Care; County Health Ranking

Public Health District 7

(2017)

1. * BRFSS YRBS Vital Stats; High-risk reports on WIC participants; Idaho Immunization Program reports; CDC; National Immunization Survey.

(2016)

BRFSS; Community Health Rankings; PRATS; Vital Stats.

(2015)

County Health Rankings; www.communityhealth.hhs.gov; Truven Market Planner; www.capc.org; www.getpalliativecare.org; www.caringinfo.org; iweb.nhpco.org; www.healthmetricsandevaluation.org; www.dataplace.org; www.cdc.gov; www.CHNA.org; www.datawarehouse.hrsa.gov; www.worldlifeexpectancy.com/usa-health-rankings; community and healthcare surveys;

Acronym Dictionary

1305 – Shorthand for the federal grant titled “State and Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health”. 1305 is the federal grant number.

ADA / AADE – American Diabetes Association / American Association of Diabetic Educators

BRHPC – Bureau of Rural Health and Primary Care.

CDC – Centers for Disease Control and Prevention

CHEMS – Community Health Emergency Medical Services

CoIIN – Collaborative Improvement and Innovation Network to Reduce Infant Mortality

CY – Calendar Year, January 1 through December 31

DPH – Division of Public Health

DPP – Diabetes Prevention Programs

DSME – Diabetes Self-Management Education

DPRP – Diabetes Prevention Recognition Program

EMS – Emergency Medical Services

IAEYC – Idaho Association for the Education of Young Children

IDHW – Idaho Department of Health and Welfare

IHC – Idaho Healthcare Coalition

ISU – Idaho State University

NRT – Nicotine Replacement Therapy

PCMH – Patient Centered Medical Home

PHD – Public Health District

RC – Regional Health Collaborative

SHIP – Statewide Healthcare Innovation Plan

SFY – State Fiscal Year, July 1 through June 30

WHCRT – Women’s Health Check Real Time database

WIC – Special Supplemental Nutrition Program for Women, Infants and Children

WISPr – WIC Information System Program